

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Filing may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 4 6								
												REG. NO.								
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST LEE			MIDDLE A.			LAST Abbott, JR.			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 12:55 AM		
3. SEX MALE			4. RACE CAUC			5. DATE OF BIRTH MONTH 4			DAY 16			YEAR 23			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico			MD.								
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mate			12b. KIND OF BUSINESS OR INDUSTRY Fish Boat											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Virginia			13c. CITY OR TOWN Lancaster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS White Stone			Box 1078								
14. FATHER'S NAME FIRST Lee			MIDDLE A.			LAST Abbott, Sr.			15. MOTHER'S MAIDEN NAME FIRST Elva			MIDDLE LAST George								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. unknown			17. INFORMANT 225-20-6890 Mrs. Joan S. Abbott (wife) same as 13			ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Carcinopulmonary Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS					
{ DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction												4 hrs								
{ DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease												YAS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (his hospital) attended the deceased from 9/9/81 to 9/10/81, that (we) last saw the deceased alive on 9/10/81, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We did/did not) view the body after death.												22b. SIGNATURE Donald M. Wong								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. M. Wong			22e. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 9/10/81											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/13/81			23c. NAME OF CEMETERY OR CREMATORIAL White Stone Baptist Ch. Cem., White Stone, Virginia			23d. LOCATION CITY OR TOWN			COUNTY STATE								
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 16 1981			25b. REGISTRAR'S SIGNATURE Anne Jane North														

oath

Sworn before me this 1st day of January 1861

Wm. H. Davis

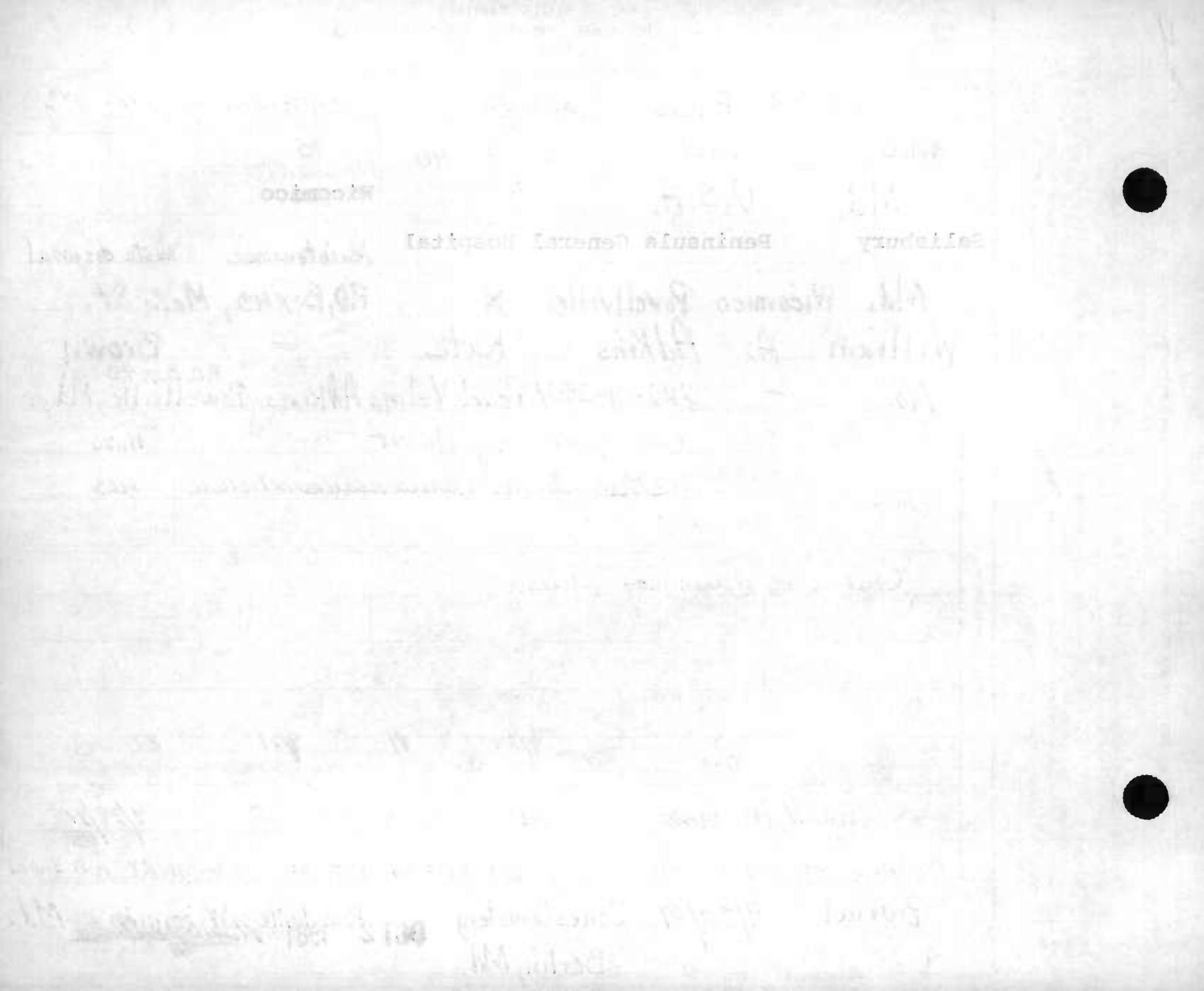
13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	8	4	7
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
LESTER Rice ADKINS						SEPTEMBER 28, 1981						7:45 A.M.						
3. SEX			4. RACE		S. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE			CAUC		6	3	1911	70			MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Md.			U.S.A.					Wicomico										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Peninsula General Hospital									Maintenance			Waste disposal			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?		13f. STREET ADDRESS							
Md. Wicomico			Md.		Wicomico		Pawterville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 43, Main St.							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
William A. Adkins			Kate															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY			ADDRESS							
No.			220-01-2559		Pearl Velma Adkins, Pawterville, Md.						P.O. Box 43							
											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
											MINS							
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)						HRS						
4292			Cardiopulmonary Arrest															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
Obstructive Pulmonary Disease																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>81</u> , to <u>7/28</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>7/28</u> , 19 <u>81</u> , and that in (<u>✓</u>) our opinion death occurred on the date and hour and from the causes stated above. (<u>✓</u>) We did not view the body after death.																		
22b. SIGNATURE			DEGREE						22c. DATE SIGNED									
Donald M. Wood MD			MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9/28/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
DONALD M. WOOD MD			QUINCY & LOCUST STS. SALISBURY MD 21801															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Burial			9/30/81		Jones Cemetery			Pawterville			Wicomico		Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS						DATE OF BURIAL/TRANSPORT									
Anna A. Burge			Berlin, Md.						OCT 2, 1981									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24848	
1- STATE REGISTRAR			LAST						2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		MONTH DAY YEAR		MONTH DAY YEAR		2d HOUR		
LARRY E. AMSPACHER							9-12-81 19		9-12-81 19		12:25 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	
Male		White		7 3 56		25 yrs.						9-12-81 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
York, Pa.		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Wicomico		Salisbury		Peninsula General Hospital	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Pa.		York		Glen Rock		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD 3		Glenn L.		Amspacher Rosaleen Gladfelter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		170-38-3867		Glenn L. Amspacher, (father) same as 13		Drowning				minutes			
9102		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		{		DUE TO, OR AS A CONSEQUENCE OF							
(b)				{		DUE TO, OR AS A CONSEQUENCE OF							
(c)				{		DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
11:15 AM 9-12-81				Drowned while swimming in ocean.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET 2nd St., Ocean City, Worcester, Md.									
		ocean		CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		and in my opinion									
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED 9-14-81									
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 9/15/81		23c. NAME OF CEMETERY OR CREMATORIUM Jerusalem (Fissels) Cem.		23d. LOCATION CITY OR TOWN Shrewsbury Township, York, Pa.							
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 16 1981		25b. REGISTRAR'S SIGNATURE James J. North							
BP _____													
DHMH-17 (VRA15 ME(5)) 15M 2/80													

Colmbo

Colombia - San Jose - Bogota - Medellin

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Colombia - San Jose - Bogota - Medellin

Colombia - San Jose - Bogota - Medellin

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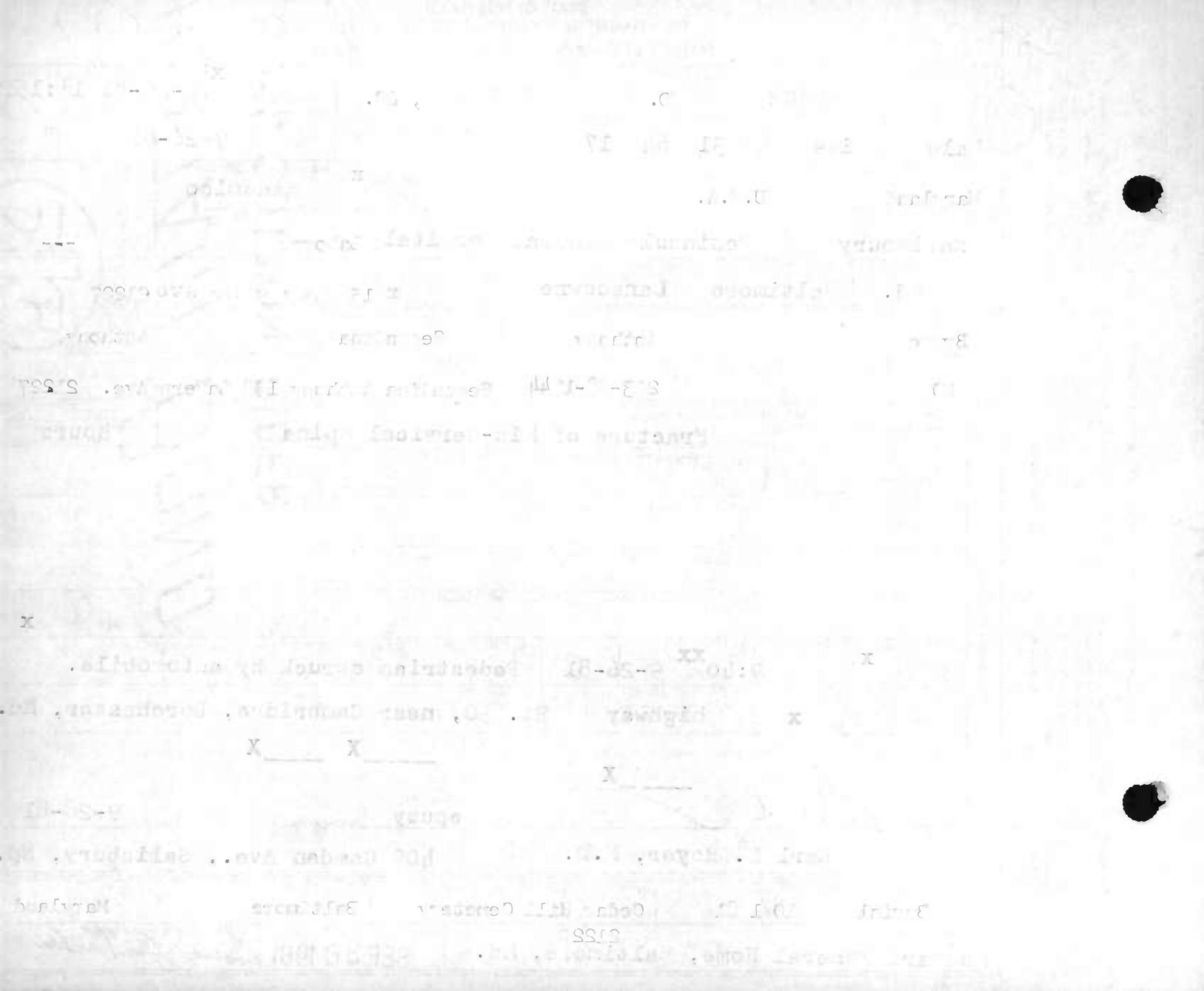
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Colombia - San Jose - Bogota - Medellin

Colombia - San Jose - Bogota - Medellin

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES.
**AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24849
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR 11:15PM		
BRUCE			D.	ANTHONY	JR.	9-26-81	11	19				
4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 11			
Male White	5 31 64	17	MONTHS	DAYS	2e. DATE PRONOUNCED DEAD	19						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico								
Maryland	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>									
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. STATE Md.	13b. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 158 Lavern Avenue 21227									
14. FATHER'S NAME FIRST Bruce	MIDDLE	LAST Anthony	15. MOTHER'S MAIDEN NAME FIRST Sequndina	MIDDLE	LAST Anthony							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT Sequindina Anthony 158 Lavern Ave. 21227	ADDRESS									
NO	213-88-1744											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Mid-Cervical Spine APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 8147 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 9:40 P.M. 9-26-81	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by automobile.										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway	21f. LOCATION STREET Rt. 50, near Cambridge, Dorchester, Md.										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE												
TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.												
ADDRESS 409 Camden Ave., Salisbury, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 10/1/81	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN Baltimore	23e. COUNTY Maryland	23f. STATE Maryland							
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home	ADDRESS 21229	25a. DATE REC'D. BY REGISTRAR SEP 30 1981										
				25b. REGISTRAR'S SIGNATURE Dances Jean Nathan								
BP	DHMH-17 (VRA15 ME(5)) 15M 2/80											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 24850		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
CHARLES E. Brown, Jr.					Brown, Jr.	September 23 1981						M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Caucasian		MONTH	DAY	YEAR	70			MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		9 BALTIMORE CITY OR COUNTY OF DEATH			Wicomico				
Virginia			USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Salisbury			Peninsula General Hospital									12b. KIND OF BUSINESS OR INDUSTRY retired waterman		
13. STATE			14. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Virginia			Accomack		Greenbackville		<input checked="" type="checkbox"/> NO <input type="checkbox"/>		rural					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Charles E. Brown, Sr.						Anna								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
no			182-05-4393		Hilda T. Brown			Greenbackville, Va.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks.		
5860			DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)									Chronic ? disease		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
RIGHT UPPER Lobe INFILTRATE														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 21, 1981, to Sept. 22, 1981, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 22, 1981, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> not view the body after death.														
22b. SIGNATURE Allen W. Justin, M.D.			DEGREE						22c. DATE SIGNED 9/23/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. Justin, M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/26/81			23c. NAME OF CEMETERY OR CREMATORIAL Union Franklin City			23d. LOCATION CITY OR TOWN Cem. Greenbackville			STATE Acc. Va.		
24. FUNERAL DIRECTOR NAME Scott S. Nelson			ADDRESS Pocomoke City, Md.						25a. DATE REC'D. BY REGISTRAR SEP 29 1981			25b. REGISTRAR'S SIGNATURE Diane Jean Harter		
83														
701														
3														
29														
1														

120

1700100

monsoon season. Inserted insulation

Leads to insulation thickness about 10 mm.

After 10 days, insulation thickness is about 10 mm.

After 10 days, insulation thickness is about 10 mm.

After 10 days, insulation thickness is about 10 mm.

X

After 10 days, insulation thickness is about 10 mm.

After 10 days, insulation thickness is about 10 mm.

After 10 days, insulation thickness is about 10 mm.

After 10 days, insulation thickness is about 10 mm.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3124851	
1. DECEASED NAME (TYPE OR PRINT)			FATHER JOHN L. MIDDLE			LAST BRYANT UNKNOWN			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
(Mr X)									September 3, 1981			805 M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			Black			MONTH 5 DAY 1 YEAR 26			55			MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			DAYS	
Texas			U.S.A.						Wicomico			HOURS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MIN.	
Salisbury			Peninsula General Hospital									MD.	
USUAL RESIDENCE (IF NOT IN CITY OR TOWN OF DEATH)			INSTITUTION (GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			Westover Labor Camp	
13a. STATE Md			13b. COUNTY Somerset			13c. CITY OR TOWN Princess Anne							
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME							
Dad. Yes													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Princess Anne, Md	
Dad. Yes						Deputy Sheriff, Somerset C'ty							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intra ventricular hemorrhage</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Intra cerebellar hemorrhage</i> 5 days													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> 19 <u>81</u> to <u>7/3</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED <u>9/11/81</u>	
22b. SIGNATURE <u>H. Shoumaker MD</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <u>52-3 1st Court</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. Shoumaker</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Removal 9/11/81			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY STATE	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 21 1981			25b. REGISTRAR'S SIGNATURE <u>Anna Jean Harter</u>				
Anatomy Board													

1-749-8505

SA Game 9/30
912-324-5454
Call back Wednesday

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed or death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 2 4 8 5 2
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Wanna			M.		Carrow	September 1, 1981				10 30	A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		July 25, 1907		74		MONTHS		HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
W. VA.		U.S.A.						Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head Center						NONE			MD.
13a STATE			13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS			
MD.			WICOMICO		TYASKIN							
14. FATHER'S NAME			FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			
VANCE McCARY							CORA JEAN BROCHARD		234-34-9997			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			234-34-9997		MRS MARY J. JOHNSTON		TYASKIN, MD.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <i>carcinoma of the colon with metastases to lung + liver</i> DUE TO, OR AS A CONSEQUENCE OF <i>1539</i>												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>COPD</i>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>August 18, 1981</i> to <i>September 1, 1981</i> , that (I) (we) last saw the deceased alive on <i>September 1, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.												
22b. SIGNATURE <i>Nancy W. Tustin, M.D.</i>			DEGREE			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <i>Deer's Head Center</i>									
Nancy W. Tustin, M. D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>9/2/81</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>DELMARVA CREMATORY</i>			23d. LOCATION <i>LEWIS, DEL.</i>			
CREMATION												
24. FUNERAL DIRECTOR NAME			24a. DATE REC'D. BY REGISTRAR <i>SEP 4 1981</i>			24b. REGISTRAR'S SIGNATURE <i>Zaneen Jean Nathan</i>						
WILSON FUNERAL HOME SALISBURY, MD.												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 2 4 8 5 3			
												REG. NO.			
1. FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			9-3-81		8:05PM	
WILBUR Ernest									CASSELL, Jr.						
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male			White			July 2, 1914			67						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
Maryland			USA									9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales			
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 522 Alabama Ave.			
14. FATHER'S NAME Wilbur Ernest Cassell			15. MOTHER'S MAIDEN NAME Catherine												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-05-0390									17. INFORMANT (son) P.O. Box 431 Mr. G. Webb Cassell, Ocean City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4960</u> chronic obstructive pulmonary disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>Sept. 2, 1981</u> to <u>Sept. 3, 1981</u> , that (I) <u>last</u> saw the deceased alive on <u>Sept. 3, 1981</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.															
22b. SIGNATURE <u>Rodney A. Wenrich</u>			22c. DEGREE MD									ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/3/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RODNEY A. WENRICH</u>			22e. ADDRESS KAY AVE SALISBURY MD 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/8/81			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park			23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland			23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR SEP 9 1981									25b. REGISTRAR'S SIGNATURE <u>James Jan Warren</u>			
BP _____															
DHMH - 16 50M 1/81 (VRA 15, 4)															

Winton

Designated Geologist

Winton Lab

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use at the burial/cremation permit. Then please send carbon copies, Pages 1 and 2 should be sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Elsie			Coard	September 30, 1981				2:50P.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR August 17, 1910			6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maid			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md	13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 107 Glenwood Ave.			
14. FATHER'S NAME George	MIDDLE Harric	LAST	15. MOTHER'S MAIDEN NAME Bertie		16. SOCIAL SECURITY NO. 25:36-0483			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. —	17. INFORMANT Sergus A Phoenix		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Desbster Miller, ASEVD, CVA								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (he) (this hospital) attended the deceased from August 7, 1981 to September 30, 1981 , that (we) last saw the deceased alive on September 30, 1981 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.								
22b. SIGNATURE E. P. Ritchings, M.D.	22c. DEGREE			22d. DATE SIGNED 9/30/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. Ritchings, M. D.	22e. ADDRESS Deer's Head Center, Salisbury, MD 21801							
23a. BURIAL, CREMATION, REMOVAL CREMATION	23b. DATE 10/5/81	23c. NAME OF CEMETERY OR CREMATORIAL Sandtown Cem.			23d. LOCATION CITY OR TOWN Salisbury	COUNTY	STATE	
24. FUNERAL DIRECTOR Lever & Dashnull Easton MD	ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 7 1981	25b. REGISTRAR'S SIGNATURE James J. Nathan		
DHMH - 16 50M 1/81 (VRA 15, 4)								

1. *U. S. Fish Commission*

2. *U. S. Fish Commission*

3. *U. S. Fish Commission*

4. *U. S. Fish Commission*



5. *U. S. Fish Commission*

6. *U. S. Fish Commission*

7. *U. S. Fish Commission*

8. *U. S. Fish Commission*

9. *U. S. Fish Commission*

10. *U. S. Fish Commission*

11. *U. S. Fish Commission*

12. *U. S. Fish Commission*

13. *U. S. Fish Commission*

14. *U. S. Fish Commission*

15. *U. S. Fish Commission*

16. *U. S. Fish Commission*

17. *U. S. Fish Commission*

18. *U. S. Fish Commission*

19. *U. S. Fish Commission*

20. *U. S. Fish Commission*

21. *U. S. Fish Commission*

22. *U. S. Fish Commission*

23. *U. S. Fish Commission*

24. *U. S. Fish Commission*

25. *U. S. Fish Commission*

26. *U. S. Fish Commission*

27. *U. S. Fish Commission*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 8 1 2 4 8 5 5														
1 - FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a DATE OF DEATH MONTH DAY YEAR					
Dryden ALFORD COLONNA									SEPTEMBER 22, 1981					
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
MALE			WHITE			SEPT 23, 1911			69 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
Maryland			U.S.A.											
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman Rot. Nestle Co			12b KIND OF BUSINESS OR INDUSTRY Salesman Rot. Nestle Co					
13a STATE Maryland			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 311 E. College Ave		
14. FATHER'S NAME George ALFORD			MIDDLE Colonna			15. MOTHER'S MAIDEN NAME Carrie Dryden								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. WWII 214-10-9510			17. INFORMANT Edna J Colonna			ADDRESS Same 1513C					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>diabetes mellitus</u>														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 22, 1981</u> to <u>Sept. 22, 1981</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Sept. 22, 1981</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.												22c DATE SIGNED 9/22/81		
22b. SIGNATURE Rodney A. Wenrich						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH						22e. ADDRESS KAY AVE. SALISBURY Md. 21801								
23a BURIAL, CREMATION, REMOVAL BY			23b. DATE 9/25/1981			23c NAME OF CEMETERY OR CREMATORIAL Wic. Mem. P.			23d. LOCATION Salisbury Md.					
24 FUNERAL DIRECTOR NAME Hill-Baker-Bandy			ADDRESS Salisbury Md.			25a DATE REC'D. BY REGISTRAR SEP 25 1981			25b REGISTRAR'S SIGNATURE James D. Thompson					
BP														
DHMH - 16 50M 1/B1 (VRA 15, 4)														



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 1 2 4 3 5 6			
										REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		2b HOUR		
			<i>Howard E. Corbin</i>						<i>September 3, 1981</i>		<i>5 40 A.M.</i>		
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR # UNDER 24 HRS		
<i>Male</i>			<i>Negro</i>			<i>3 - 3 - 1893</i>			<i>88</i>		MONTHS DAYS HOURS MIN.		
7c BIRTHPLACE STATE OR FOREIGN COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
<i>Maryland</i>			<i>USA</i>						<i>Wicomico</i>				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
<i>Salisbury</i>			<i>Peninsula General Hospital</i>						<i>Farmer</i>				
13a STATE <i>Maryland</i>										13b COUNTY <i>Worcester</i>		13c CITY OR TOWN <i>Snow Hill</i>	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET ADDRESS <i>406 W. Market St.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
<i>John Corbin</i>			<i>Georgiana Unknown</i>										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>			<i>215265240</i>			<i>Audrey Deshields, Snow Hill Md.</i>							
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<i>Acute Pulmonary Edema</i>			
1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Renal Failure Secondary to Obstruction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of the Prostate with Metastasis to the bone</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>8/27</i> , 19 <i>81</i> , to <i>9/3</i> , 19 <i>81</i> . that (I) (we) lost saw the deceased alive on <i>9/3</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/3/81</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
<i>BENITO S. CHAN</i>			<i>547-D Riverside Drive</i>										
23a BURIAL, CREMATION, REMOVAL			23b DATE			23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN					
<i>Burial</i>			<i>9-6-81</i>			<i>St. James</i>		<i>Snow Hill Maryland</i>					
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR		NAME					
<i>Norman F. Dennis, Snow Hill, Md.</i>						<i>SEP 9 1981</i>							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24357

REG. NO.

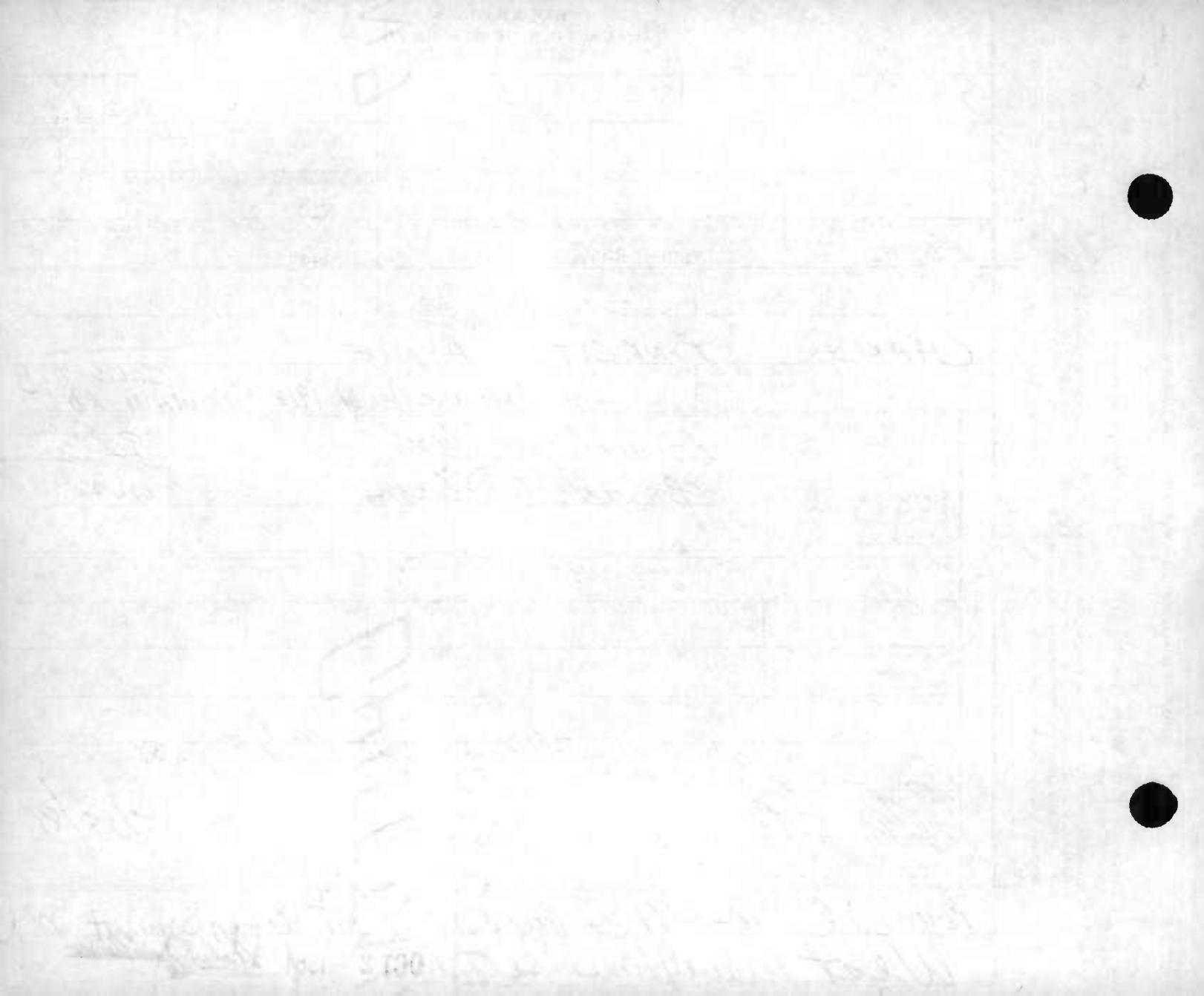
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be presented within 24 hours after death. Page 4 may be

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

THE INFLUENCE OF THE ENVIRONMENT ON THE DISEASES OF HUMANS

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
PEARL			CROPPER			9	27	1981		11:25AM		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6 18 1897			6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO					
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. 10				
14. FATHER'S NAME CHARLES			15. MOTHER'S MAIDEN NAME ANNIE			17. INFORMANT Florence Handly 1916 SPRINGHILL RD.			ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 156-18-4819			17. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH 30 days						
18. CAUSE OF DEATH: Enter only one cause per box for Part I, II, and III. PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cultural Shock</i> 4340 Conditions, if any, which gave rise to immediate cause (b) <i>open atrio ventricle</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <i>yes</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I-II												
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN THIS BOX, PART I OR PART II)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE	
22a. I certify that (i) this hospital attended the deceased from <u>1980</u> to <u>1981</u> that (ii) we last saw the deceased alive on <u>1980</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If we witnessed did not view the body after death.												
22b. SIGNATURE <i>John J. Kelly</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>9/18/81</u>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH C. FITZGERALD			22g. ADDRESS SALISBURY, MD. 21801									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE 10-3-81		23c. NAME OF CEMETERY OR CREMATORIAL PARADISE			23d. LOCATION MOUNTAIN VIEW		23e. COUNTIES BALTIMORE			
24. FUNERAL DIRECTOR NAME West Funeral Home Sales		ADDRESS			25a. DATE REC'D. BY REGISTRAR (REGISTRATION NUMBER)			25b. SIGNATURE <i>John J. Kelly</i>				
OCT 2 1981												

BP _____



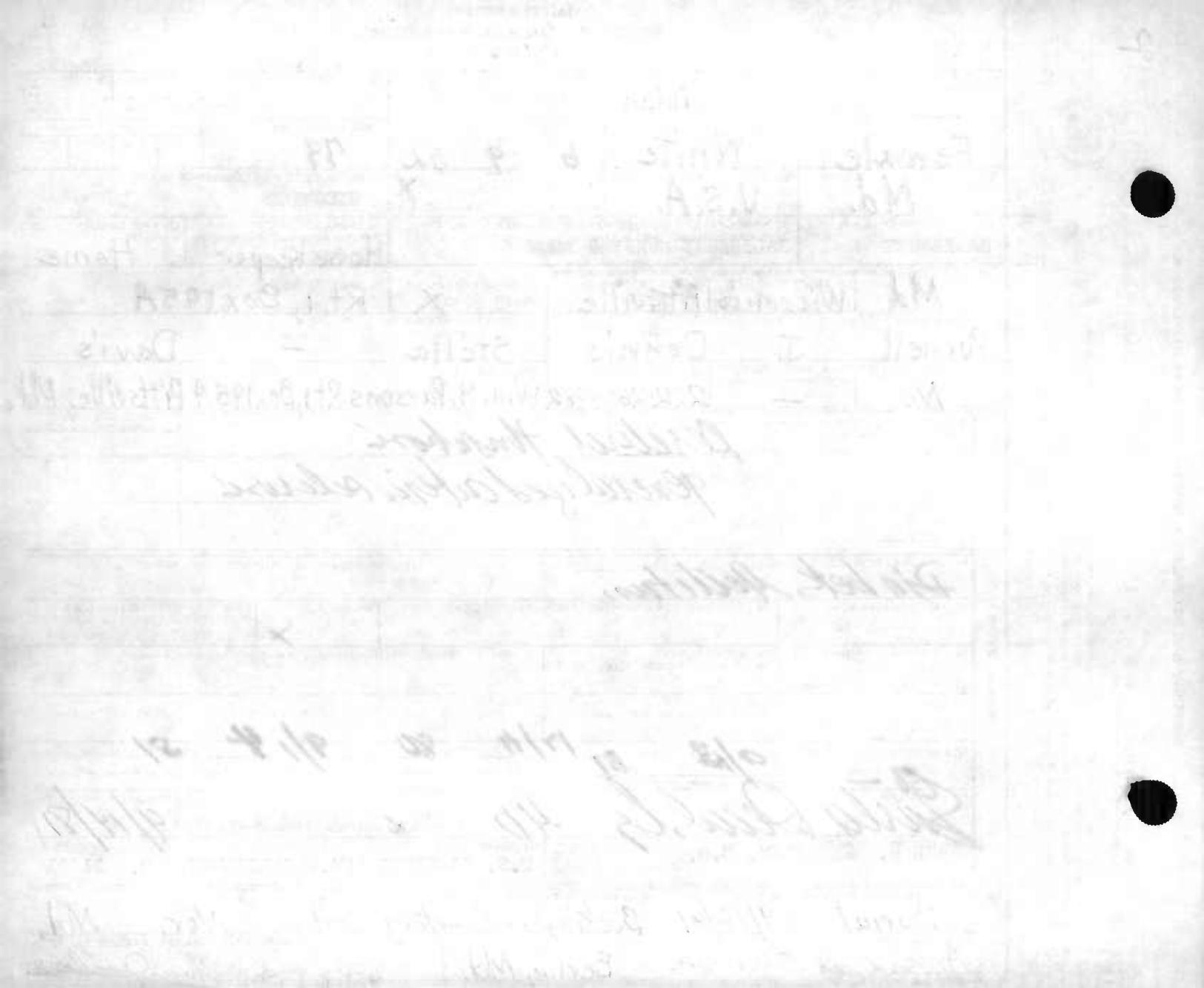
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be continued

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 5 8	
												REG. NO.	
1 - STATE REGISTRAR			I. DECEASED NAME [TYPE OR PRINT]			FIRST EDNA	MIDDLE Lillian	LAST DENNIS	2a. DATE OF DEATH 9--14-1981			MONTH YEAR 1:45 a.m.	
3 SEX Female			4 RACE White			5. DATE OF BIRTH MONTH 6 DAY 9 YEAR 02			6. AGE [IN YEARS LAST BIRTHDAY] 79 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			MD.	
10 CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SALISBURY NURSING HOME						12a. USUAL OCCUPATION House Keeper			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE [IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION] Md			13b. COUNTY Wicomico			13c. CITY OR TOWN Pittsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1, Box 195A	
14 FATHER'S NAME First Purnell			15 MOTHER'S MAIDEN NAME First Dennis			16 SOCIAL SECURITY NO 222-26-4882			17 INFORMANT Wm. H. Parsons			ADDRESS Rt. 1, Box 195A Pittsville, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for 1a, 1b, and 1c.] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4340 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) generalized arterio sclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetes Mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II]							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>12/10/80</u> to <u>9/14/81</u> , that (1) (we) last saw the deceased alive on <u>12/10/80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. We did not view the body after death.													
22b. SIGNATURE Anne M. Beardsley, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/14/81				
22d. PHYSICIAN'S NAME [TYPE OR PRINT] EARL M. BEARDSLEY, M.D.			22e. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801										
23a. BURIAL, CREMATION, REMOVAL [SPECIFY] Burial			23b. DATE 9/16/81			23c. NAME OF CEMETERY OR CREMATORIAL Buckingham Cemetery			23d. LOCATION CITY OR TOWN Berlin			23e. COUNTY Wor.	23f. STATE Md.
24 FUNERAL DIRECTOR NAME Anne A. Turso			ADDRESS Berlin, Md.			25a. DATE REC'D. BY REGISTRAR -- SEP 21 1981			25b. REGISTRAR'S SIGNATURE Anne A. Turso				



2 Copies

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24359				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> OF EST. DEATH MATED <input type="checkbox"/>			MONTH	DAY	YEAR	2b. HOUR				
Louis Lee Dillard						IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.					
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)									2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Black	01 03 51	28 yrs.									9 11 1981	1:35 a.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
U.S.A.		U.S.A.						Wicomico County, MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury		Peninsula General Hospital														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland		Wicomico		Salisbury				205 Delaware Ave. Salisbury								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
Howard				Dillard	Edna Dillard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
		unk		Mother												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Stab wound of chest																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF																
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
1 XM. 9 11 1981				subject stabbed												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
		street		Lake St.		Salisbury		Wicomico		MD.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY) Deputy Chief M.D. MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.												DATE SIGNED 9/12/81				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
Burial		09-18-81		Green Acres Men. Pk.		Salisbury		Wicomico		Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Russell A Hooks		725 Riverside Dr. Salisbury, Md.		1991		Thomas J. Martin										
BP																
DHMH-17 (VRA15 ME(5))																
15M 2/80																



CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

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2000

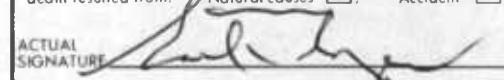
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CONFIDENTIAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24360					
1. DECEASED NAME (TYPE OR PRINT)			Marguerite			MIDDLE Mary			LAST Dodge			2a. DATE KNOWN OF ESTI- MATED	MONTH 9	DAY 6	YEAR 1981	2b. HOUR 5:57 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 18 R. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR 5:57 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		New York		May 29, 1918			63 RS.							9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Peninsula Inn									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN Bowie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 12413 Chalford Lane					
14. FATHER'S NAME Edward			MIDDLE —			LAST Walsh			15. MOTHER'S MAIDEN NAME Margaret			16. ADDRESS Bowie, Md.			O'Boyle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 115-12-7629			17. INFORMANT Marcus T. Dodge, 12413 Chalford La.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>As CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															years		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		
ACTUAL SIGNATURE 															DATE SIGNED 9-7-81		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 409 Camden Ave. Salisbury Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE Burial 9/11/81				23c. NAME OF CEMETERY OR CREMATORIAL Md. Nat'l. Memo. Pk.				23d. LOCATION Laurel, Maryland					
24. FUNERAL DIRECTOR NAME				Beall Funeral Home				25a. DATE REC'D. BY REGISTRAR SEP 14 1981				25b. REGISTRAR'S SIGNATURE Priscilla Jean Weston					

12 C.P. 10000 Annuities R. " Dowie, Esq.
Sect'l Auditor's House
111 N.E. 1st Street, New York, N.Y.
Sept 14, 1901
Gentlemen:
I am directed by the Board of Directors of the
Bankers' Trust Company to inform you that
the amount of the premium paid by the
Bankers' Trust Company on its stock
of the New York Stock Exchange
is \$1,000,000.
Very truly yours,
John D. Jones
Chairman
Bankers' Trust Company

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 6 6 1	
												REG. NO.	
1 - STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Evelyn Bermont Evans			September 25, 1981			5 46 PM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				
Female			White			April 16, 1916			65 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia			USA						Wicomico MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital			Housewife							
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Wicomico			Salisbury			303 S. Haven Ave.				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
(unknown)			(unknown)										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			214-07-9558			Mrs. Dixie Speakes (daughter)			same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PONTINE HEMORRHAGE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS	
4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) HYPERTENSION												4 YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. NONE													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-24, 1981, to 9-25, 1981, that (I) (we) last saw the deceased alive on 9-25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9-25-81	
22b. SIGNATURE Richard E. Bird			DEGREE MD			CONSULTING ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD E. BIRD			22e. ADDRESS 233 FLORIDA AVE., SALISBURY, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/28/81			23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland				
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 29 1981			25b. REGISTRAR'S SIGNATURE Dancer Jean Warden				
DHMH-16 25M (VRA 15, 4) 1/79													

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Instigations General Banknotes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	6	6	2
1 - FOR STATE REGISTRAR				REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Lenn						Fernandes	Sept	29	81	8	45	PM	8 45 PM					
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		White			MONTH	Dec	DAY	91	89			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		USA			MARRIED	<input type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	Wicomico					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury				Deer's Head Center														
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland				Wicomico		Salisbuyr		YES	<input checked="" type="checkbox"/>	NO	<input type="checkbox"/>	405 Royall Street						
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS								
Adenilo						Fernandez	UNKNOWN			405 ROYAL ST., SALISBURY, MD 21801								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No				225-42-5366A			ERNIE DIXON			minutes								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:				immediate cause (a) myocardi'al infarction														
4100				DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.				DUE TO, OR AS A CONSEQUENCE OF (c)														
4 years																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
mild renal insufficiency																		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED				
Nancy W. Tustin, M.D.														9-29-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			Deer's Head Center SALISBURY MD											
Nancy W. Tustin																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL PARSONS Cemetery			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial				10/2/81						SALISBURY, WIC.			MD.					
24. FUNERAL DIRECTOR NAME				ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			RE					
BAKER & Bounds				SALISBURY, Md.			OCT 5 1981			Frank J. Smith								

2000-10-20

ADDRESS

183 6700

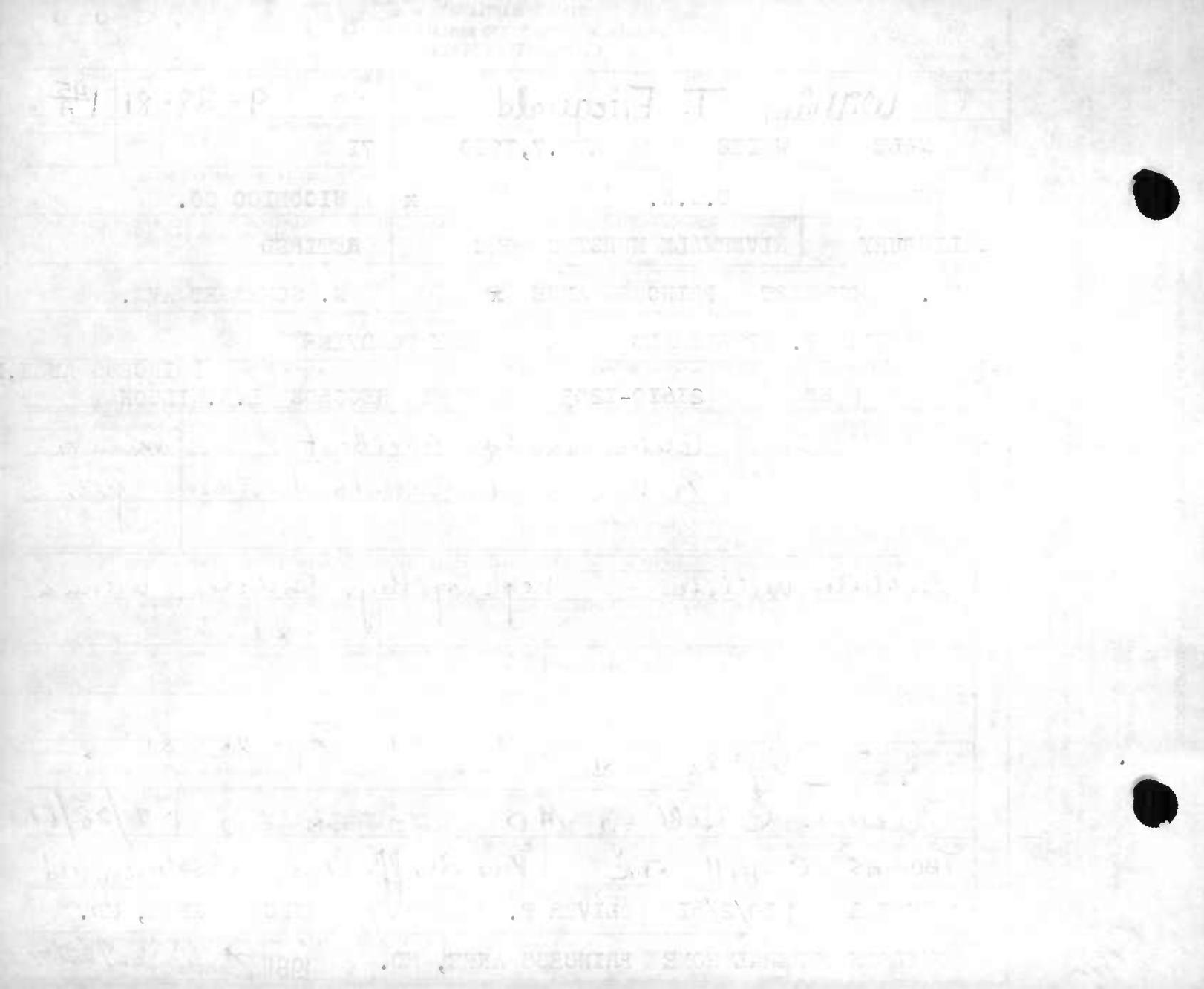
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. - age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 6 3			
1 - STATE REGISTRAR				REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
William T. Fitzgerald							7 9-28-81						145	1/1 A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS					
MALE		WHITE		AUG. 7, 1910		71		MONTHS		YEARS	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 DATE OF DEATH		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.							
SOMERSET		U.S.A.				WICOMICO CO.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
SALISBURY		RIVERWALK NURSING HOME		RETIRED											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		N. SOMERSET AVE.					
MD.		SOMERSET		PRINCESS ANNE											
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME											
WILLIAM P. FITZGERALD				RUBY TOADVINE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		PRINCESS ANNE, MD.							
NO		21610-1203		FROM HIS RECORDS		L.R. WILSON									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>												Minutes			
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Vascular Disease</i>												year			
{ DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE
22a. I certify that (this hospital) attended the deceased from <i>Jan 2 1981</i> to <i>Sept 28 1981</i> , that (we) last saw the deceased alive on <i>Sept 28 1981</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.															
22b. SIGNATURE				22c. DEGREE				22d. DATE SIGNED							
Thomas C. Hill Jr. MD								9/28/81							
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>															
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS											
THOMAS C. HILL, JR.				<i>Pine Bluff Road, Salisbury, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY/TOWN		MD.					
WILSON FUNERAL HOME PRINCESS ANNE				10/2/81		OLIVER T. BEAUCHAMP									
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
WILSON FUNERAL HOME PRINCESS ANNE, MD.				PCT 2 1981				Thomas Jan Hartley							



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 6 4	
1 - FOR STATE REGISTRAR				2a DATE OF DEATH MONTH DAY YEAR								REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	September 27, 1981				2b HOUR	6:55 P M	
Armond						FLOWERS	SR.						
3. SEX MALE				4. RACE NEGRO			5. DATE OF BIRTH MONTH 10 DAY 07 YEAR 00			6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED FARMER			12b. KIND OF BUSINESS OR INDUSTRY COUNTY			
13a. STATE MARYLAND				13b. COUNTY DORCHESTER	13c. CITY OR TOWN VIENNA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE #1, BOX 14				
14. FATHER'S NAME FIRST FRANK				MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST HANNAH			MIDDLE	LAST	HALEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 243-18-6026			17. INFORMANT FANNIE MAE FLOWERS			ADDRESS SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma of lung 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 19				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/27 87 to 9/27 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/29/87	
22b. SIGNATURE I. Hwang				22d. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I Hwang, M.D.				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 10/2/81			23c. NAME OF CEMETERY OR CREMATORIAL WALLACE'S			23d. LOCATION CITY OR TOWN RHODESDALE		COUNTY DORCHESTER	STATE MD.
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL				25a. DATE REC'D. BY REGISTRAR ADDRESS Rt. #2, Jersey Rd. SALISBURY, MARYLAND			25b. REGISTRAR'S SIGNATURE OCT 8 1981						

• 100% COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24865				
1- STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST									2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 9-11-81 11PM				
			JOSEPHINE BAILEY FRITTS									2b. HOUR				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-12-81 19 3 AM				
Female		White		6 18 45			36			MONTHS DAYS HOURS MIN		MD.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico						
Virginia				U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 13 & Salisbury bypass										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hutzler's		
Salisbury																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md.		Wicomico		Salisbury						Lavale Court						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME												
Willie				Shirley												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(If Yes, give war or dates)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No		---		231-58-3843			Chester Fritts			See Sec. 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet Wound of Heart Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 11 P.M. 9-11-81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted gunshot wound.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
					Rt. 13, north of Salisbury, Wic., Md.											
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER											DATE SIGNED 9-14-81			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1109 Camden Ave., Salisbury, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-1981			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION CITY, TOWN, COUNTY Salisbury, Wicomico, Md.			STATE					
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 16 1981			25b. REGISTRAR'S SIGNATURE								
BP																
DHMH-17 (VR A15 ME (5)) 15M 2/80																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if retained by the hospital or attending physician.

Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	4	6	6	6
										REG. NO. 9 --- 06 - 1981						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P M							
ELIZABETH SHIVERS GOLDSMITH						9 --- 06 - 1981			11:30 M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
Female		White		July 12, 1893			88									
7a. BIRTHPLACE (STATE OR PROVINCE COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.					WICOMICO									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
SALISBURY		SALISBURY NURSING HOME								Homemaker Own Home						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Wicomico		Salisbury						Civic Ave & Rt 50						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
John H. Shivers Sr.		Luva F. Payne														
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO		217-32-0351		Jack E. Beardsley			6366 Beering Rd.			6 weeks						
19. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY.																
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>																
4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <u>9/16/81</u> to <u>9/30/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. saw the deceased alive on <u>9/16/81</u> above, (he/she) (we) did not view the body after death.																
22b. SIGNATURE <u>Shirley</u>			22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>9/7/81</u>							
23a. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			U.S. 50 AT CIVIC AVE., SALISBURY, MD. 21801										
EARL M. BEARDSLEY, M.D.																
24a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE <u>9/10/1981</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Berea Hill, Dr. P.A.</u>			COUNTY		STATE		
24b. FUNERAL DIRECTOR NAME <u>Hill-Barker-Bounds</u>			ADDRESS <u>Salisbury Md.</u>			23e. DATE REC'D. BY REGISTRAR <u>SEP 14 1981</u>			23f. REGISTRAR'S SIGNATURE <u>Shirley</u>							

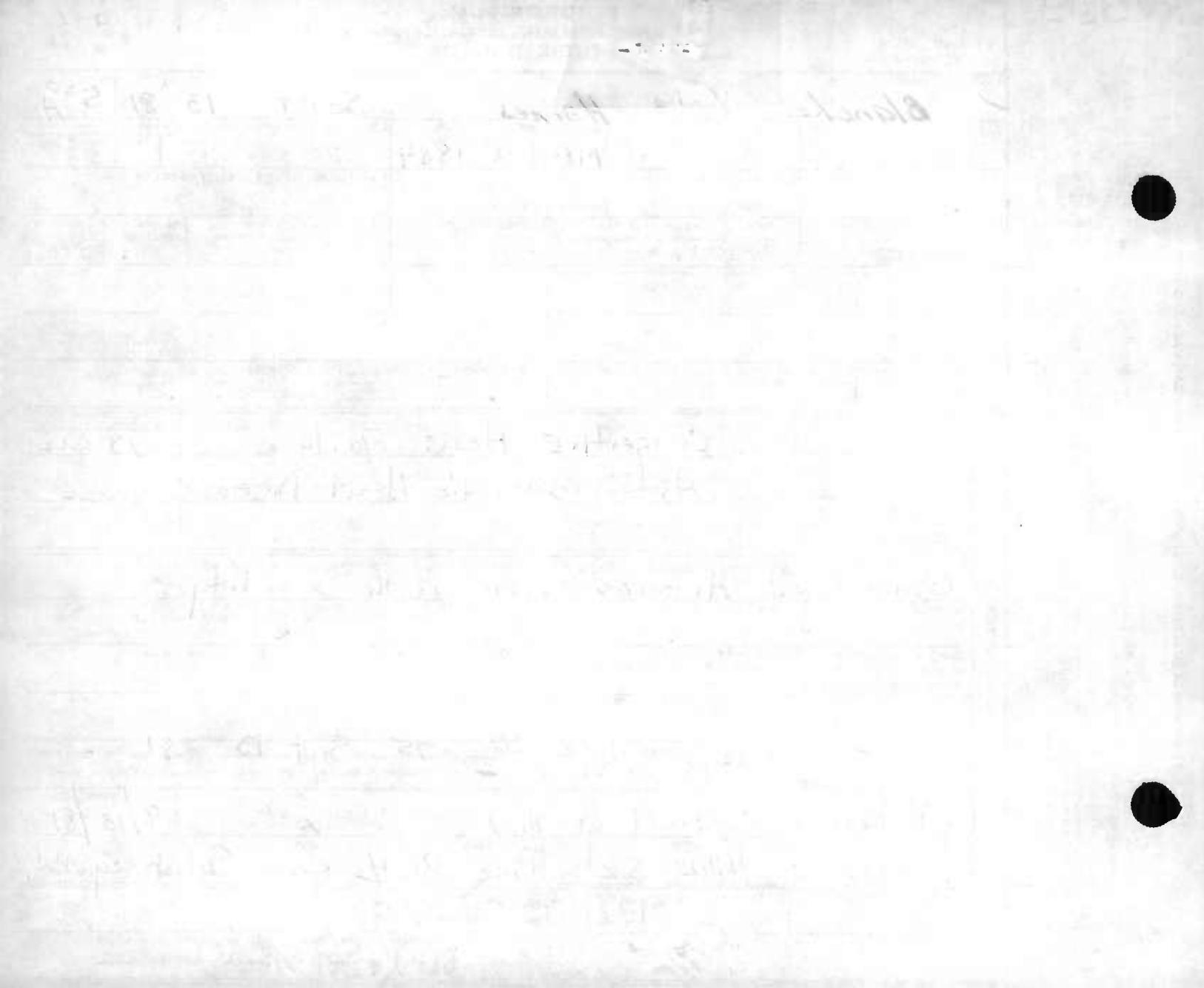
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 16 shows any injury, or other traumatic event, the medical examiner must be contacted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 24361		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		SEPT 13 '81		5:50 A.M.	
Blanche Viola Haimes												
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		# UNDER 24 HRS	
Female			White		Month Day Year March 2 1884		97 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO		MD.			
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverwalk Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store					
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Hebron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Quercus Drive			
14 FATHER'S NAME William			15 MOTHER'S MAIDEN NAME Fessler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17 INFORMANT (Grand-daughter) Mrs. Carol Houseal, Hebron, Md.		ADDRESS Oak Ridge Drive	
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18b. DUE TO, OR AS A CONSEQUENCE OF (b)		18c. DUE TO, OR AS A CONSEQUENCE OF (c)		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs					
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Congestive Heart Failure		Arteriosclerotic Heart Disease Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis with Senility												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec 26 1975 to Sept 13 1981, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept 13 1981, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE Thomas C. Hill Jr.			22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED 9/13/81					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas C. Hill Jr.			22f. ADDRESS Pine Bluff Road, Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/16/81		23c. NAME OF CEMETERY OR CREMATORIUM Northwood Cemetery		23d. LOCATION CITY OR TOWN Philadelphia,		COUNTY		STATE Pa.	
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS SEP 16 1981		25e. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE							
DHMH-16 25M (VRA 15, 4) 1/79												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 4 8 6 8		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<u>MARGARET</u>					<u>HASTINGS</u>	<u>9 6 81</u>						<u>0530 AM</u>		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
<u>FEMALE</u>			<u>WHITE</u>		<u>JULY 13, 1934</u>		<u>47</u>			MONTHS	DAYS	HOURS	MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<u>MARYLAND</u>			<u>U.S.A.</u>		<u>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></u>		<u>WICOMICO</u>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<u>Salisbury</u>			<u>Peninsula General Hospital</u>											
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
<u>MD.</u>			<u>WICOMICO</u>		<u>PARSONSBURG</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>WASTE GATE RD.</u>					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
<u>JAMES POWELL</u>			<u>VIRGIE BAILEY</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
<u>NO</u>			<u>220-28-0812</u>			<u>HAROLD HASTING</u>			<u>PARSONSBURG, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Melathelioma</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/5</u> 81, 1981, to <u>8/6</u> 1981, that (I) (we) last saw the deceased alive on <u>9/5</u> 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>David E. Powell</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/6/81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID E. POWELL</u>			22e. ADDRESS <u>1300 S. Division St. Salisbury, MD. 21801</u>											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <u>BURIAL</u>			23b. DATE <u>9/9/81</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>WICOMICO MEM. PARK</u>			23d. LOCATION <u>SALISBURY, MD.</u>			COUNTY		STATE
24. FUNERAL DIRECTOR NAME <u>WILSON FUNERAL HOME</u>			ADDRESS <u>SALISBURY, MD.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 9 1981</u>			25b. REGISTRAR'S SIGNATURE <u>James Jean Mathews</u>					

Designated members guidelines

THE DAY COULD

RIGHT

RIGHT SIDE SIDE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 6 9			
												REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Jesse Clyde HEINTZ						9-20-81			2:30 PM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE			WHITE			3 28 1895			86 yrs.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
PA			USA						WICOMICO						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury			RIVERWALK MANOR			RET. LABORER			U.S. STEEL						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md.			Somerset			EDEN						RT. 1 Hickory Acres			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
BERNARD HEINTZ			EVIA BROWN			YES 1851059			172-07-284X Gloria Banks - Hickory Acres			EDEN, MD. 21822			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized arteriosclerosis</u> (c)												4125			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Congestive Failure</u>															
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9-29-77 to 9-20-81, that (I) (we) last saw the deceased alive on 9-25-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															
22b. SIGNATURE <u>J. S. Berkley</u>			22c. DEGREE MD.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-20-81						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/23/81			23c. NAME OF CEMETERY OR CREMATORIAL MC. VERNON CEM.			23d. LOCATION CITY OR TOWN ELIZABETH - ALLEGHENY - PA.			COUNTY STATE			
Burial															
24. FUNERAL DIRECTOR NAME Hill-Baker-Banks			ADDRESS Salisbury Md.			25a. DATE REC'D. BY REGISTRAR SEP 25 1981			25b. REGISTRAR'S SIGNATURE Frances Jean Hartman						

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STATEMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please attach it to the burial permit. Then please remove certain papers. Pages 1 and 2 should be detached for use on the burial permit. Then please remove certain papers. Pages 3 and 4 should be filed within 24 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORT UNIT: If item 21 is marked or item 18 shows any injury, or unless traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	6	1	0
1 - FOR STATE REGISTRAR															REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH				MONTH	DAY	YEAR	2d HOUR						
Dale		William	Hicks		SEPTEMBER				3, 1981			5:55 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.						
Male		White		Sept. 3, 1981		0				MONTHS		DAYS						
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH				YRS.		HOURS						
Salisbury, Md.		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico				2		51						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
Salisbury		Peninsula General Hospital										none						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS									
Donald		Gary	Hicks		YES				P.O. Box 281									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME				16. STREET ADDRESS										
NO				Elizabeth Ann				Bowen										
17. INFORMANT Mr. Donald G. Hicks (father) same as 13																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST.</u> 7469 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGENITAL HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 3, 1981</u> , to <u>Sept. 3, 1981</u> , that (I) (we) last saw the deceased alive on <u>Sept. 3, 1981</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													22c. DATE SIGNED <u>Sept 4, 1981</u>					
22b. SIGNATURE <u>RUTH I. McDONALD MD, PhD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RUTH I. McDONALD</u>		22e. ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>										
23a. BURIAL, CREMATION, REMOVAL SPECIAL Burial		23b. DATE 9/6/81		23c. NAME OF CEMETERY OR CREMATORIAL Union Church Cemetery		23d. LOCATION Salisbury, Wicomico, Maryland												
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR SEP 8 1981		25b. REGISTRAR'S SIGNATURE <u>James J. Weston</u>														

positive
and National League members
should

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 81 24871
1 - FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
ANNE J. HOLLAND						9 27 1981 6:35 AM
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS
FEMALE		W		10 07 1896		84 YRS IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.
10 CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a STATE MD.		13b COUNTY WICOMICO		13c CITY OR TOWN SALISBURY		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS 1007 RIVERSIDE DRIVE
14. FATHER'S NAME FIRST Julien		MIDDLE B.		LAST Johnson		15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE F. LAST Johnson ADDRESS Ocean City, Md.
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN		17 INFORMANT 215-22-1420 Inez H. Lusby		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastral ulceria</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>ASCVD. Generalized</i> (c) <i>yes</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN COUNTY STATE
22a. I certify that (I) (the hospital) attended the deceased from <i>4-6-81</i> , 19, to <i>9-27-81</i> , 19, that (I) (we) last saw the deceased alive on <i>9-27-81</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <i>Joseph C. Fitzgerald</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>9/27/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH C. FITZGERALD		22e ADDRESS SALISBURY, MD. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-27-81		23c. NAME OF CEMETERY OR CREMATORIAL Cape Henlopen Funeral Home, Crem.		23d. LOC. ATION CITY OR TOWN Lewes COUNTY Sussex DE.
24. FUNERAL DIRECTOR NAME Larimore R. Pippin (131)		25. DATE REC'D. BY REGISTRAR ADDRESS Lewes, De. OCT 5 1981 Signature				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 4 8 7 2			
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST					
William Thomas Holland, Jr.				FIRST		MIDDLE		LAST					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR					
Male		White		Jan. 24, 1918		63		8:20A.M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Maryland		USA				WICOMICO				YRS		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Salisbury		Deer's Head Center								12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Wicomico		Salisbury				228 Canal Park Dr., G201					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16. ADDRESS					
William		Thomas		Holland, Sr.		Jane		Kirwan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW II		218-05-7436		Mrs. Emily G. Holland, Salisbury, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>4275</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>CVA & hemiplegia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
<input type="checkbox"/> ACCIDENT WAS UNDERLYING (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that he this hospital attended the deceased from August 18, 1981, to September 10, 1981, that he (we) last saw the deceased alive on September 10, 1981, and that in my our opinion death occurred on the date and hour and from the causes stated above, he (we) did not view the body after death.										22c. DATE SIGNED <i>9/10/81</i>			
22b. SIGNATURE <i>E. P. Ritchings, M.D.</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		9/12/81		Parsons Cemetery		Salisbury		Wicomico		Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HOLLOWAY FUNERAL HOME, Salisbury, Maryland				SEP 14 1981		<i>James Jan North</i>							

100% of responses

Effort

efficiency

ORIGIN

return base reward

variable

by step size

10% of responses 10% of responses 10% of responses

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SEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 81 24873					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR August 27 1981									2b. HOUR 11P M					
1. DECEASED NAME (TYPE OR PRINT)			FIRST LAURA	MIDDLE D.	LAST HOPKINS	6. AGE (IN YEARS AT LAST BIRTHDAY) 86			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS HOURS 0 MIN. 0					
3. SEX Female			4. RACE WHITE			5. DATE OF BIRTH MONTH MAY 1 DAY YEAR 1895			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE DE			13b. COUNTY SUSSEX			13c. CITY OR TOWN LEWES			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Route 1, Box E 727					
14. FATHER'S NAME FIRST JAMES			MIDDLE T.	LAST Futcher	15. MOTHER'S MAIDEN NAME Lydia			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 221-32-0954			17. INFORMANT ERNEST F. Hopkins, LEWES, DE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1549 Renal failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ≈ 2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) Jaundice												≈ 3 days					
DUE TO, OR AS A CONSEQUENCE OF (c) Probable Pancreatic and Liver malignancy												≈ 2 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Heart failure - Senility - Occult gastrointestinal bleeding																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/25 1981 to 8/27 1981, that (I) (we) last saw the deceased alive on 8/27 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8/27/81					
22b. SIGNATURE			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/31/81			23c. NAME OF CEMETERY OR CREMATORIAL CONLEY'S CHAPEL			23d. LOCATION CITY OR TOWN ANGOLA			COUNTY SUSSEX STATE DE.					
24. FUNERAL DIRECTOR NAME WM. G. SIMMON JR.			ADDRESS FRANK FORD, DC.			25a. DATE REC'D. BY REGISTRAR SEP 16 1981			25b. REGISTRAR'S SIGNATURE								

102

7000 ft. up to 10000 ft. high

12.2

Intercostal nerve at midline, median

ANESTHESIA - Nitrous oxide + oxygen + 2% isoflurane + 0.05% fentanyl

WOB (1)

WOB (2) - fentanyl

100 mg fentanyl + 100 mg fentanyl + 100 mg fentanyl

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 7 4			
												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			FLORENCE L JENNINGS						Sept. 1 1981						12:58 AM
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			WHITE			MONTH JAN. DAY 28, YEAR 1883			98			MONTHS	YEARS	MONTHS	HOURS MIN.
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
CONN.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			WIcomico						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury			Peninsula General Hospital			NONE									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
MD.			WICOMICO			SALISBURY			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
FRANK BARNES						ESTELLE MEAD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO						RUSSELL JENNING			SALISBURY, MD.						
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>pneumonia</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>congestive heart failure</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>Aug 31, 1981</u> to <u>Sept 1, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug 31, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Rodney A. Wenrich, MD</u>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/1/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rodney A. WENRICH</u>						22e. ADDRESS <u>KAY AVE. SALISBURY Rd. 21801</u>									
23a. BURIAL, CREMATION, REMOVAL BY CARRIER			23b. DATE <u>9/3/81</u>			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
BURIAL						WICOMICO MEM. PARK SALISBURY, MD.									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>SEP 3 1981</u>			25b. REGISTRAR'S SIGNATURE <u>Doris Jan Warner</u>						
WILSON FUNERAL HOME			SALISBURY, MD.												

Monocots

Grasses Poaceae Gramineae 禾本科

X Cereals 小麦 玉米 水稻

18

71%

101

180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and completely fill in by the funeral director. Page 4 must be retained by the hospital or attending physician.



Page 4 must be
retained by the hospital or attending physician.

12

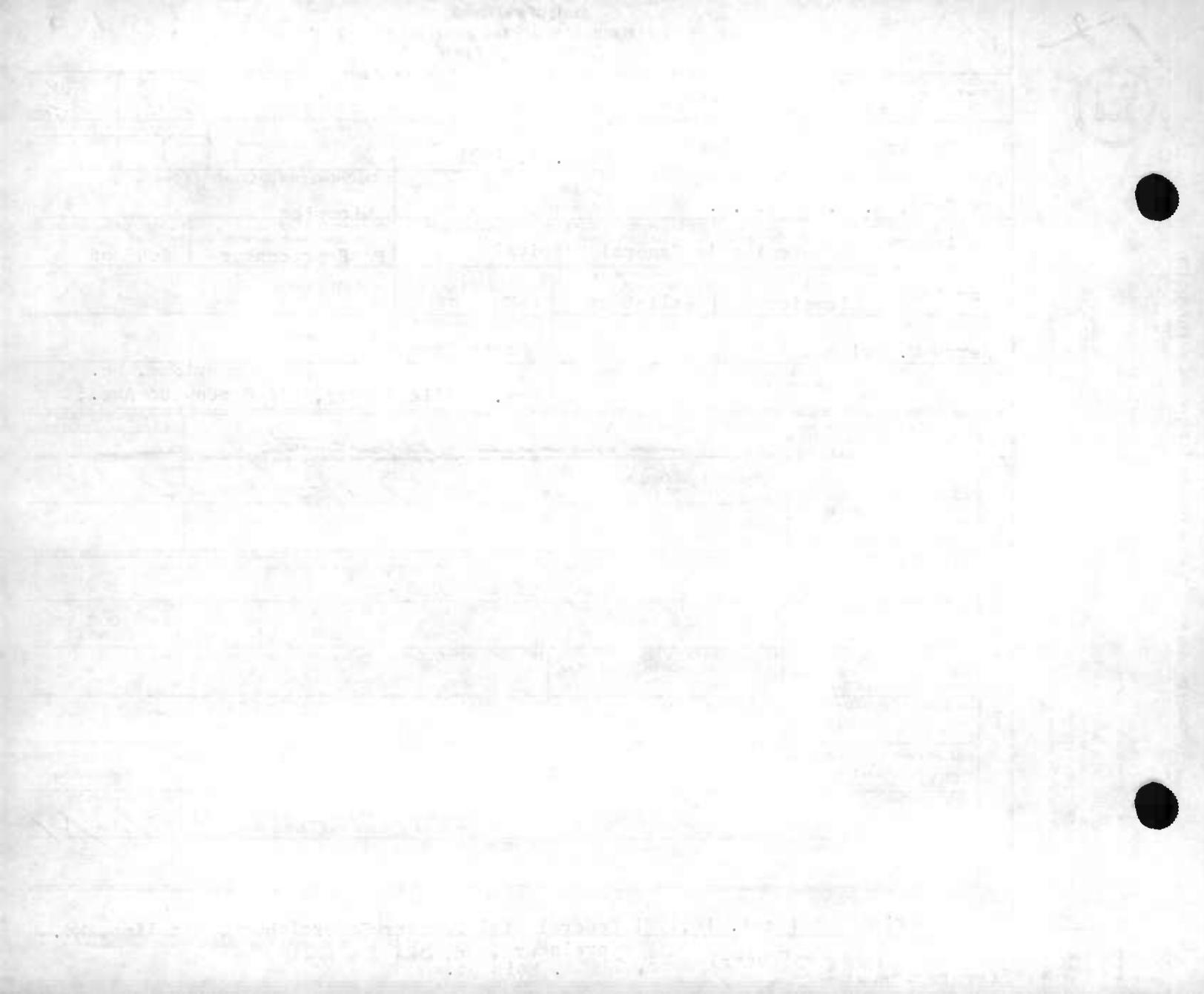
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 4 8 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
DASIEY MAE JONES						SEPTEMBER	10	1981		10 28 AM		
3. SEX		4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Black	Month Day Year			49		MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Beauford, N. C.		U.S.A.					Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital			Food processor		Seafood					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury								
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Jerry K. Smith					Marie Vann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
NO					Mrs. Mollie Hughes, 616 Greenwood Ave.,		Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, c and d.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						Has						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Electrocardiologist</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute myocardial infarction</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Stroke of myocardial infarct</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/11/81</u> , 19 <u>81</u> , to <u>9/11/81</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>9/11/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>J. S. Hawkin</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/14/81</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		Sept. 16, 1981			Federal Hill Cemetery		Federalsburg					
24 FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Frampton-Hawkins		Funeral Home, 216 N. Main St.			SEP 10 1981							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item #23b per phone call w/Fun. Hom 9/9/81 rc 1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 1 2 4 8 7 6	
						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Henry	MIDDLE JONES	LAST	2a. DATE OF DEATH MONTH DAY YEAR September 6, 1981	
3. SEX MALE			4. RACE NEGRO	5. DATE OF BIRTH MONTH 2 DAY 15 YEAR 18	6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANNIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
13a. STATE MARYLAND			13b. COUNTY WICOMICO	13c. CITY OR TOWN FRUITLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS P.O. BOX 826	
14. FATHER'S NAME FIRST HENRY			MIDDLE JONES SR.	LAST	15. MOTHER'S MAIDEN NAME FIRST SADIE	MIDDLE WILSON	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	16c. ADDRESS 215-18-0205	17. INFORMANT NORMA JONES	18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b1), and (c1). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung & metastases DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>E.P. Ritchings, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9/6/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. RITCHINGS M. D.		22e. ADDRESS Deer's Head Center, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12th 9/13/81	23c. NAME OF CEMETERY OR CREMATORIAL MT. CALVARY U.M. CEM.		23d. LOCATION CITY OR TOWN FRUITLAND WICOMICO MARYLAND		
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL		ADDRESS JERSEY ROAD	25a. DATE REC'D. BY REGISTRAR SEP 9 1981		25b. REGISTRAR'S SIGNATURE <i>Frances Jan Kithen</i>		



only one

dated 1900

and now you are

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in

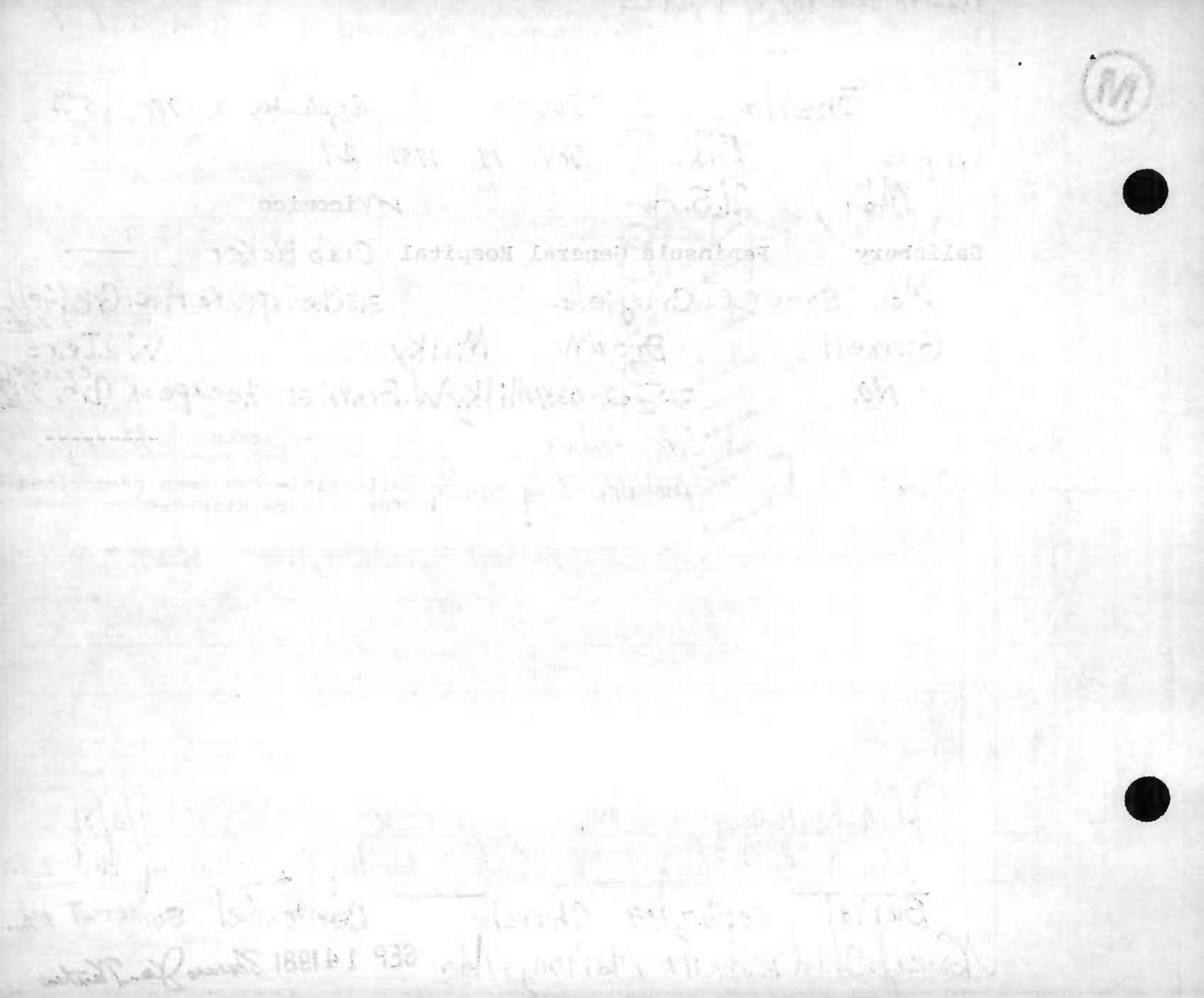
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 CERTIFICATE OF DEATH										REG. NO. 1 2 4 8 7 1			
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Sheila</i>			MIDDLE <i>Jones</i>		LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 5:30 A.M.			
3. SEX <i>Female</i>		4. RACE <i>Blk.</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 19 1951</i>			6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>			MD.				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Crab Picker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>							
13a. STATE <i>Md.</i>		13b. COUNTY <i>Somerset</i>			13c. CITY OR TOWN <i>Crisfield</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>318 Chesapeake Ave Crisfield Md.</i>				
14. FATHER'S NAME FIRST <i>Garnell</i>		MIDDLE <i>—</i>			LAST <i>Brown</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Milky</i>			MIDDLE <i>—</i>			LAST <i>Waters</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>25-62-0337</i>			17. INFORMANT <i>Milky W. Brown</i>			ADDRESS <i>318 Chesapeake Ave. Crisfield Md.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 weeks</i>				
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1c) PART I. DEATH WAS CAUSED BY <i>5728</i>		IMMEDIATE CAUSE (a) <i>Liver failure</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>probable drug toxicity</i>			DILANTIN - had been prescribed for seizure disorder							
Conditions, if any, which gave rise to immediate cause 1(a), stating the underlying cause lost															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>John A. Rountenberg</i>		22c. DEGREE <i>MD.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>9/3/81</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John A. Rountenberg</i>		22f. ADDRESS <i>Suite 31 Wesley Dr. Salisbury Md. 21801</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 7, 1981</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Church</i>			23d. LOCATION CITY, TOWN <i>Centenniel Somerset</i>							
24. FUNERAL DIRECTOR NAME <i>Norman Ward</i>		ADDRESS <i>P.O. Box 119 Marion, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 14 1981</i>			25b. REGISTRAR'S SIGNATURE <i>James Janith</i>							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,

BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24678	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR
JAMES			E.	KEENE		<input checked="" type="checkbox"/>	9-28-81		19	7:10A			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR
Male	White	3 12 59	22			<input checked="" type="checkbox"/>	9-28-81		19	11	M		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U. S. A.				<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED				Wicomico			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital				Truck Driver						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md.			Caroline		Federalsburg		YES <input type="checkbox"/>		124 Bloomingdale Ave.				
14. FATHER'S NAME FIRST			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST				LAST			
Paul					Keene	Betty				Beauchamp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS		
n/a			216-64-9706				Betty Payne				Federalsburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8/22 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													sudden
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Fractures of Right Lower Extremity with Thrombophlebitis													17 days
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 7:50 P.M. 9-12-81				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of motorcycle struck by auto.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET highway				Caroline COUNTY Houston Branch Rd., Federalsburg, Md. STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE													TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.													ADDRESS 409 Camden Ave., Salisbury, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN Federalsburg				DATE SIGNED 9-28-81	
Burial			Oct. 1,		Hillcrest			Car.				M.	
24. FUNERAL DIRECTOR NAME <i>Edgar Williamson</i>			ADDRESS Williamson Funeral Home, Federalsburg		25a. FILED BY REGISTRAR NAME <i>Edgar Williamson</i>			25b. REGISTRAR'S SIGNATURE NAME <i>Edgar Williamson</i>					
BP _____													
DHMH-17 (VR A15 ME (5))													
15M 2/80													

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10-5-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			SEPTEMBER 18, 1981 12 PM							
Everett Thomas KERNAN													
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		
Male		White		Oct. 5, 1910			70 YRS.		MONTHS DAYS		HOURS MIN		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA					Wicomico						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury		Peninsula General Hospital		Sales			Automobile						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE Md.		13c. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		926 Southerly Rd., Apt 2				
14 FATHER'S NAME FIRST Joseph		MIDDLE Thomas		LAST Kernan			15 MOTHER'S MAIDEN NAME FIRST Iva		MIDDLE Day		LAST Watson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT			ADDRESS		Apt. 2 Mrs. Kathryn M. Kernan, 926 Southerly Rd.				
No		---		217-01-6939			Mrs. Kathryn M. Kernan, 926 Southerly Rd.						
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c): PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic heart disease</u> (c) <u>Hypertensive heart disease</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>9/18/81</u> to <u>19</u> , that (1) (we) last saw the deceased alive on <u>9/18/81</u> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										9-18-81			
23a. BURIAL, CREMATION, REMOVAL LINE 1		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Cremation		1 SEP 81		Westview Crematory			Baltimore, Maryland						
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
J. E. Lowell Lemmon		10 W. Padonia Rd.		SEP 22 1981		Jan Kather							

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Georgian National Bank

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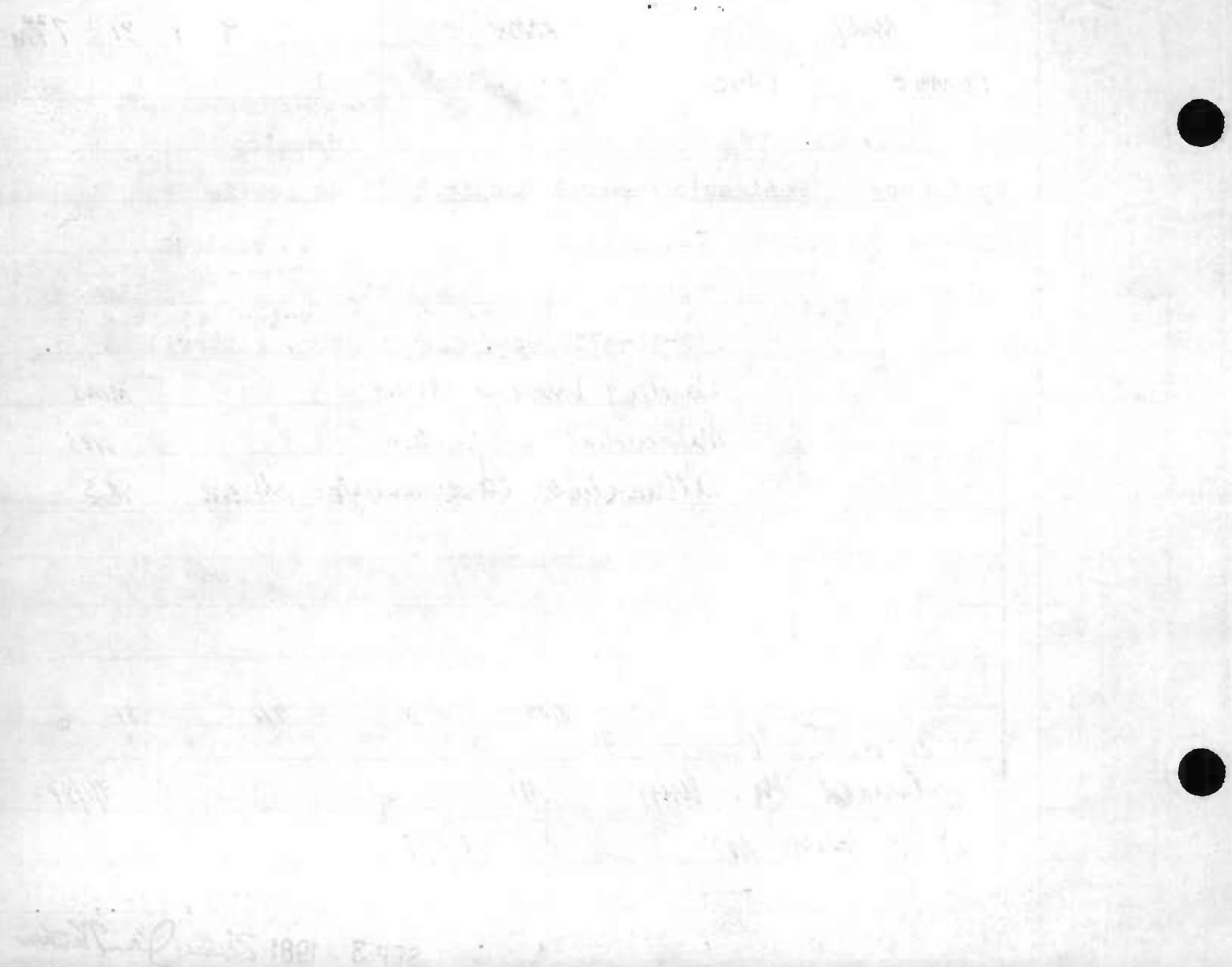
Georgian

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	8	8	0	
1 - FOR STATE REGISTRAR														REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
MARY			Lizzie	Knox		9	1	81				7 ²⁰	PM	M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 MONTH			IF UNDER 24 HRS							
FEMALE		CAUC		June 4, 1890		91			MONTHS	DAYS		HOURS		MIN.					
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Pittsville, Md.		USA							Wicomico										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Salisbury		Peninsula General Hospital		Housewife															
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13b. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS										
Maryland		Wicomico		Pittsville		YES <input type="checkbox"/> NO <input type="checkbox"/>			in village										
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			LAST										
Clem				Elliott		Charlotte			Holloway										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (daughter-in-law) Box 76			ADDRESS												
No		213-48-9716		Mrs. Calvin Knox, Pittsville, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												MINS							
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction												HRS							
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease												YRS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/1 19 81, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did not view the body after death.						22b. SIGNATURE Annelia M. Lewis			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/4/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. M. Wood, Jr.			22e. ADDRESS P644																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/4/81			23c. NAME OF CEMETERY OR CREMATORIAL Pittsville Cemetery			23d. LOCATION CITY OR TOWN Pittsville, Wic., Md.			COUNTY			STATE				
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR SEP 3 1981 Frances Jean Harten			25b. REGISTRAR'S SIGNATURE										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be submitted for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 4 8 8 1			
										REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			10. DATE OF DEATH MONTH DAY YEAR			26. HOUR 4 ³⁸ _{P.M.}	
Hilda S. Layfield									September 13, 1981				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 6-27-18			6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			MD.	
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collector Operator			12b. KIND OF BUSINESS OR INDUSTRY Printing Co.				
13a. STATE Maryland			13b. COUNTY Worcester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 104 Powell St.				
14. FATHER'S NAME Merril			15. MOTHER'S MAIDEN NAME A. Stevens			16. SOCIAL SECURITY NO. 217057684			17. INFORMANT Elwood R. Layfield, Snow Hill, Md.			ADDRESS	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (If Yes, give war or dates) No			18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18c. IMMEDIATE CAUSE (a) Cardiac arrest							
4413			DUE TO, OR AS A CONSEQUENCE OF: (b) Metabolic Acidosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF: (c) Transfusional Coagulopathy										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION 9/13/81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rupture abdominal Aorta			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 9/13/81				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-16-81			23c. NAME OF CEMETERY OR Cremation			23d. LOCATION CITY OR TOWN Snow Hill, Maryland			STAFF	
24. FUNERAL DIRECTOR NAME Norman F. Dennis, Snow Hill, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR Sep 17 1981			25b. REGISTRAR'S SIGNATURE Name: <i>James J. Fletcher</i>				
D MHM-16 25M (VRA 15, 4) 1/79													

P. Wissmann 2
S. 71-2-8 2000
Mauricio
Santos Gómez González
42 years old
Male
White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 8 8 2						
												REG. NO.						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM			MIDDLE JUDSON			LAST LIVERMAN			September 11 1981		8:30 AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White			10 - 19 - 1903			77			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD						
N.C.			U.S.A.						Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital						Dep. Chief Police			Police Dept.						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
D.C.			Washington			YES <input type="checkbox"/> NO <input type="checkbox"/>			4000 Mass Ave., N.W.									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Joseph Liverman			Annie Belle Futrell															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			578-62-1000 N			Elva P. Liverman, Wife. Same as item 13												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>						
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Disease</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>Congestive Heart Failure</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I or this hospital) attended the deceased from <u>6.25</u> 19 <u>81</u> to <u>9.10</u> 19 <u>81</u> , that (I or we) lost the deceased alive on <u>9.10</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Roger Merrill</u>												22c. DATE SIGNED <u>9/11/81</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roger Merrill</u>			22e. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/16/81			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION CITY OR TOWN Rockville-Montgomery Co.-Md.			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME <u>Jos. Gawler's Sons, Inc.</u>												ADDRESS 5130 Wisc. Ave, NW-Wash, DC						

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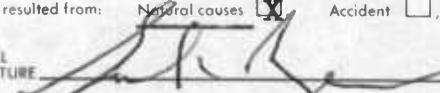
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FEBRUARY 1952

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 243883
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR
ELSWORTH GENE LLOYD						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-12-81	19	10:17A	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White	12 19 45	35 yrs.	8	23	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	9-12-81	19	11	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U. S. A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital					Railroad			Conrail		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md.		Wicomico	Delmar		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rt. 3, Box 511					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Robert E. Lloyd				Elsie M. Bullen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		1968	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS						
Yes		1968-1970	217-42-6097	E. Jean Lloyd Delmar, Md. 19940								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.												DATE SIGNED 9-14-81
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		9-15-81		St. Stephens Cem.		Delmar		Sussex		Del.		
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Marvel-Short Funeral Home, Delmar, Del.				SEP 21 1981		James Short						
BP _____												
DHMH-17 (VR A15 ME (5))												
15M2/80												

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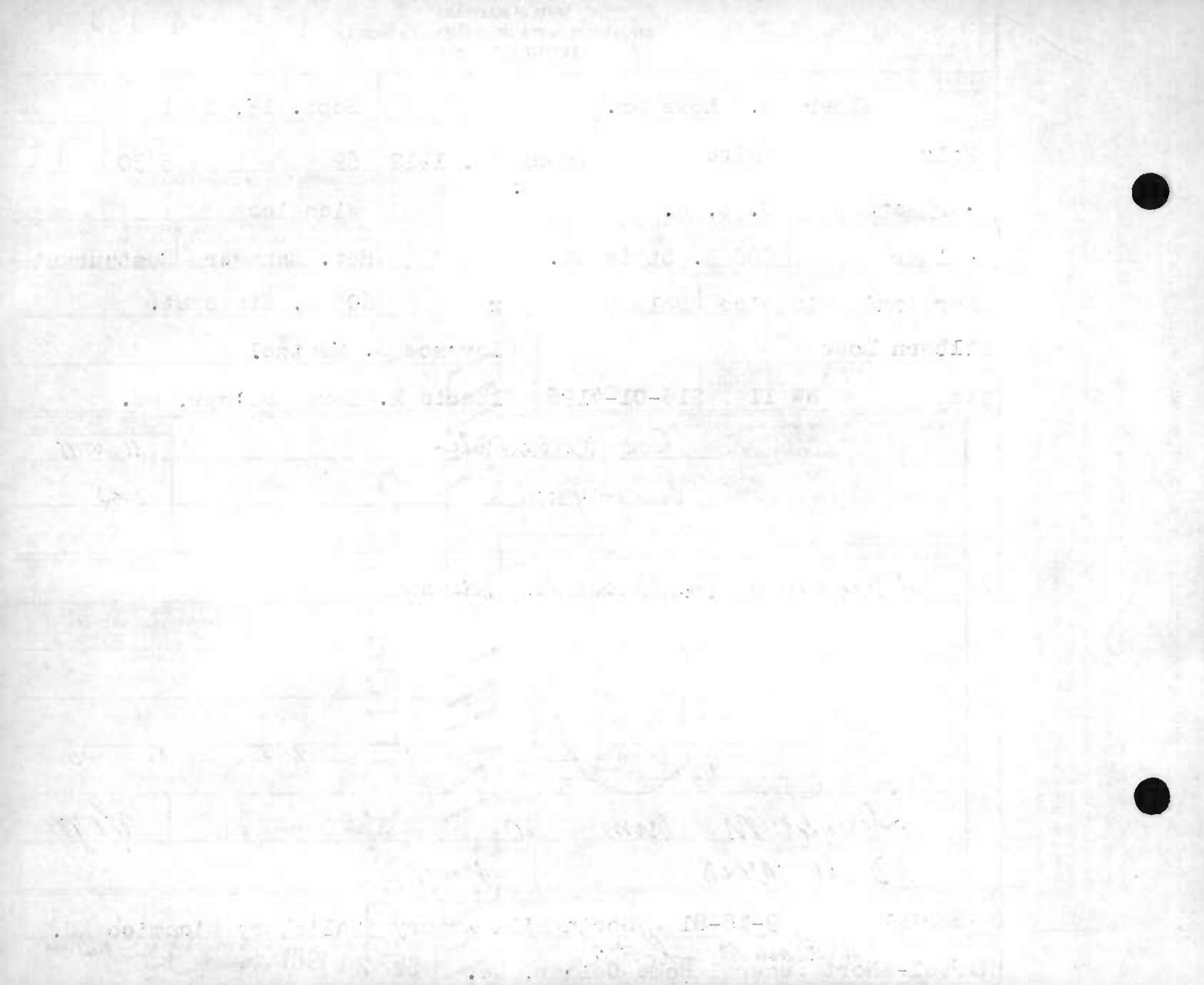
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of death beneath the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.							
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR									2b HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			Sept. 15, 1981			M				
Elmer G. Lowe Sr.																			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			White			March 25, 1912			69			YRS.		MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			Wicomico MD.							
Maryland			U. S. A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Delmar			606 E. State St.									Ret. Manager Restaurant							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland			Wicomico			Delmar						606 E. State St.							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																
Lilbern Lowe			Florence R. Mentzel																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
yes WW II			216-01-4196			Alberta M. Lowe Delmar, Md.									MONTHS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4920 COR Pulmonale																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Encephalitis													YRS			
			DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Atherosclerotic Cerebrovascular Disease</i>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/14 19 81, to 9/15 19 81, that (I/we) last saw the deceased alive on above. (We) did (did not) view the body after death.																			
22b. SIGNATURE <i>Donald M. Lum</i>			22c. DEGREE <i>m</i>									22d. DATE SIGNED <i>9/17/81</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. M. Lum</i>			22e. ADDRESS <i>P.O.H.</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>9-18-81</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Springhill Memory</i>			23d. LOCATION CITY OR TOWN <i>Salisbury Wicomico Md</i>			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME <i>William M. Marvel-Short</i>			25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <i>Frances Jean Miller</i>									SEP 21 1981							
Marvel-Short Funeral Home Delmar, De.																			



TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed together in the death record.

REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed together in the death record.

IMPORTANT: If Item 21 is marked as "Yes" above any injury, or other traumatic event, the medical examiner will be notified.

Item 19b G560 10/13/81 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 4 3 8 5

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
<i>Anita Rae Lyons</i>						<i>September 18, 1981</i>				6 05 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		
Female		White		Mar 2, 1946		35		YEARS	MONTHS	HOURS	MIN	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Wash., D.C.		USA				Wicomico						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY						
Salisbury		Peninsula General Hospital		Housewife								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d STREET ADDRESS						
Wash., D.C.		-----		Washington		2015 - 0 Street N.W.						
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME				LAST			
		Harry		Budman	Elsie				Shapiro			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		213-44-3820		Bruce D. Lyons; 2015 O Street N.W., Wash., DC				2 days				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <i>cardiac arrest</i>												
4292 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>trauma</i> <i>about</i> .												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<i>rupture of aneurysm</i>												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
9-1-81		Intracranial aneurysm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from 9-14-81 to 9-15-81, that (I) (we) last saw the deceased alive on 9-18-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b SIGNATURE <i>[Signature]</i> DEGREE												
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED 9-18-81												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS										
JAMES SPENCE, M.D.		Medical Center; Salisbury, Md.										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		9-21-81		King David Mem. Garden		Falls Church, Va.						
24 FUNERAL DIRECTOR NAME		Rockville, Md.		25 CHARGED BY REGISTRAR		REGISTRAR'S SIGNATURE						
Danzansky-Goldberg Chapels; 1170 Rockville Pike				SEP 22 1981		<i>[Signature]</i>						

45 1881-1882 December 1882
Annie Rose

November

remained mostly healthy

but

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	8	8	6	
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Russell Chester Malone												September 11, 1981						6 A M	
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
Male			White			JAN 9 1908			73			YRS			MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			U.S. A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			Wicomico										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Salsbury			Peninsula General Hospital						Superintendent										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. CURRENT ADDRESS							
Md			Wicomico			Allon						Cooper Rd. Box 93							
14. MOTHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST							
Edgar						MALONE			JENNIE			MARTIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
NO			214-30-8068			Lillian Malone			Same as 13e										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i>												Instant							
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												10 yrs							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD</i>												unk.							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypercholesterolemia</i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>1/20 1981</i> to <i>9/19 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) (did not) view the body after death.																			
21g. SIGNATURE <i>George Henratty MD</i>			21h. DEGREE <i>MD</i>			21i. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			21j. DATESIGNED <i>9/14/81</i>										
21l. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (IF ANY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE				
Burial			9/13/1981			Allon Com.			Allon			Md							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Hill-Baker-Bounds, Salsbury Md.						SEP 16 1981			Anne J. Martin										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 81 24881

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
CHARLES L MCCABE						SEPTEMBER	22	1981	12 PM					
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR					
MALE		CAUC	MONTH	DAY	YEAR	58	58	YRS	MONTHS	DAYS	HOURS	MIN		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
MARYLAND		USA			Wicomico									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury		Peninsula General Hospital			MILL OPERATOR			AGRICULTURE						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS								
13a. STATE		13c. COUNTY		13e. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT 1 Box 177						
MARYLAND		WORCESTER		BISHOPVILLE										
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST						
		FRED	L.	MCCABE	GERTRUDE			FOSKIE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			214-28-2892			MILDRED A. McCABE, BISHOPVILLE, MD			MINS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY						4100								
IMMEDIATE CAUSE (a)						Cardiopulmonary Arrest								
DUE TO, OR AS A CONSEQUENCE OF (b)						Myocardial Dystrophy								
DUE TO, OR AS A CONSEQUENCE OF (c)						Atherosclerotic Cardiovascular Disease								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
States Post Anti Valve Replacement for Aortic Stenosis														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/22 1981, to 9/28 1981, and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death						78								
22b. SIGNATURE						DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	DATE SIGNED				
D. M. Wood						MD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9/22/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			P. G. H. M. C.									
D. M. Wood														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL LINE METHODIST CHURCH			23d. LOCATION CITY OR TOWN		COUNTRY		STATE			
BURIAL		9/25/81		GAMBRO			SUSSEX		DE					
24. FUNERAL DIRECTOR NAME		ADDRESS			25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE						
Charles W. Hastings, Selbyville, Del.					SEP 28 1981			Francisco J. Santos						

BP_____

1980

Pennsylvania Geologic Survey

Geological

Map of the

Monongahela Quadrangle

1:250,000 Scale

Prepared by the Pennsylvania Geologic Survey

Under Contract with the U.S. Geological Survey

1980

Prepared by the Pennsylvania Geologic Survey

Under Contract with the U.S. Geological Survey

1980

Prepared by the Pennsylvania Geologic Survey

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 24888											
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Elizabeth			MIDDLE Marie			LAST Mc Cluskey			2a. DATE OF DEATH MONTH Sep. 19, 1981			MONTH YEAR			2b. HOUR 5:59 AM		
3. SEX <u>Female</u>			4. RACE White			5. DATE OF BIRTH MONTH Feb. 13, 1908			DAY			YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 73			IF UNDER 1 YEAR YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md.</u>			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico														
10. CITY OR TOWN OF DEATH <u>Salisbury</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Dept. Store employee</u>			12b. KIND OF BUSINESS OR INDUSTRY														
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Wicomico</u>			13c. CITY OR TOWN <u>Salisbury</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <u>Rt. 3, Airport Road</u>											
14. FATHER'S NAME FIRST (unknown)			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST (unknown)			MIDDLE			LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO <u>215-03-1572</u>			17. INFORMANT <u>Garland S. Grove, (son) same as 13</u>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4360</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u>			4 yrs																	
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Renal failure - anemia</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (1) this hospital attended the deceased from <u>Aug. 14, 1981</u> to <u>Sept. 19, 1981</u> , that (1) we last saw the deceased alive on <u>Aug. 15, 1981</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.												22b. DATE SIGNED <u>9-19-81</u>											
22c. SIGNATURE <u>John T. Bulkeley</u>			22d. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John T. Bulkeley M.D.</u>			22f. ADDRESS <u>Salisbury, Maryland</u>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>9/21/81</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>DelmarvaCrematory</u>			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
24. FUNERAL DIRECTOR <u>HOLLOWAY FUNERAL HOME, Salisbury, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 23 1981</u>			25b. REGISTRAR'S SIGNATURE <u>James Jean Hartene</u>																	
DHMH-16 25M (VRA 15, 4) 1/79																							

Capitales

Población General Norteamericana

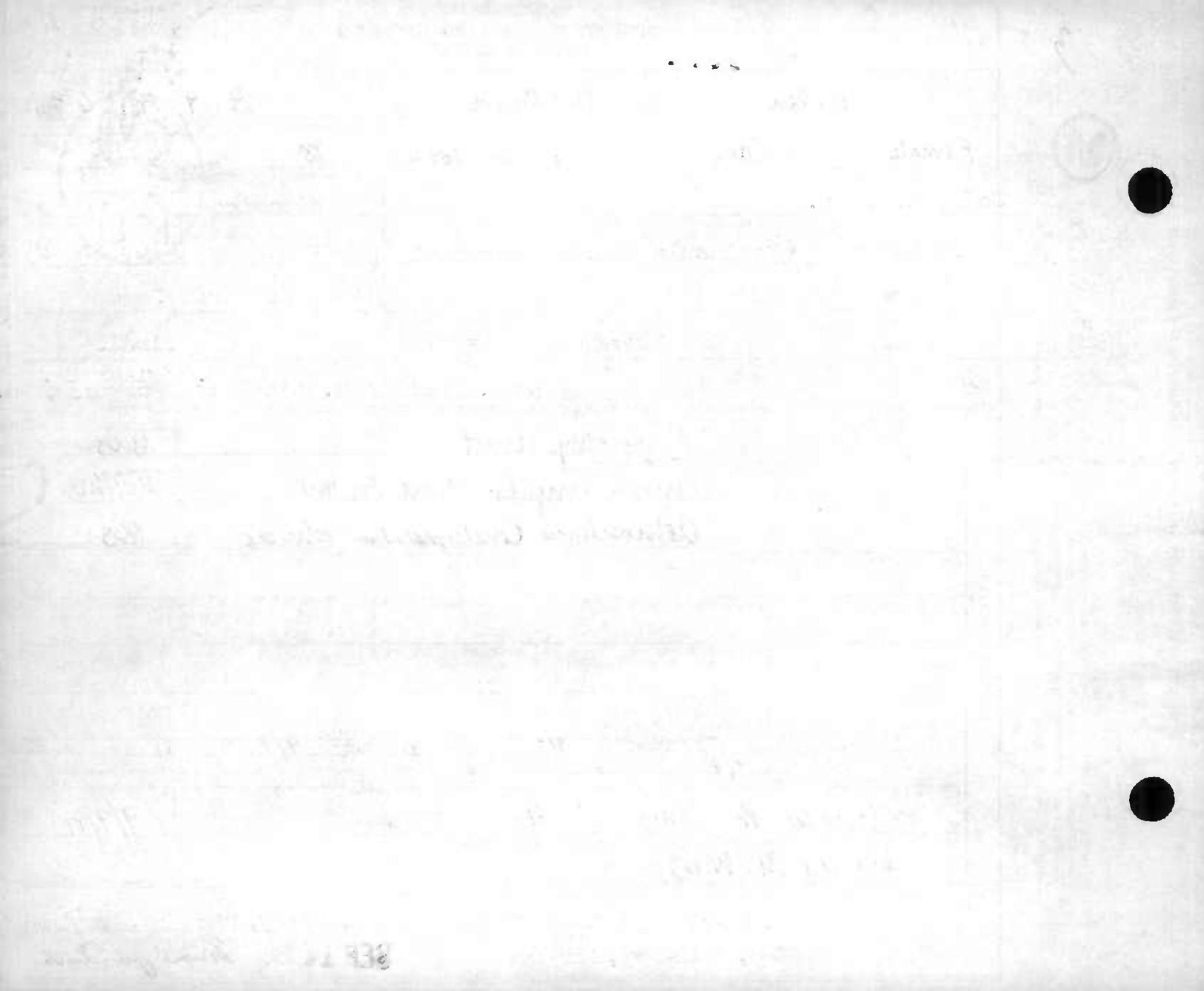
1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified at any time.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3	1	2	4	8	8	9
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Helen Mildred McDaniel						9	9	1981	9	9	1981	6:30 PM						
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR							
Female			Cauc.		MONTH	DAY	YEAR	88	YRS		MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Salisbury, Md.			USA						Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital			Owner			Clothing Store									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Wicomico		Salisbury					413 Pine Bluff Road								
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	Tindle									
Joseph				Hayman	Martha													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
NO						Mrs. Lucille M. Littleton, Fruitland, Md.			609 S. Division St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { Due to, or as a consequence of (b) <i>Arterioles Arteriole Heart Failure</i> Due to, or as a consequence of (c) <i>Arterioles Arteriole Cardiovascular Disease</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															Months			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from saw the deceased alive on 9/9/81 to 9/9/81, and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I/we) did not view the body after death.																		
22b. SIGNATURE <i>Donald M. Way</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/9/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald M. Way</i>			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/12/81			23c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland			COUNTY	STATE					
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 14 1981			25b. REGISTRAR'S SIGNATURE <i>Patricia Jean Martin</i>									

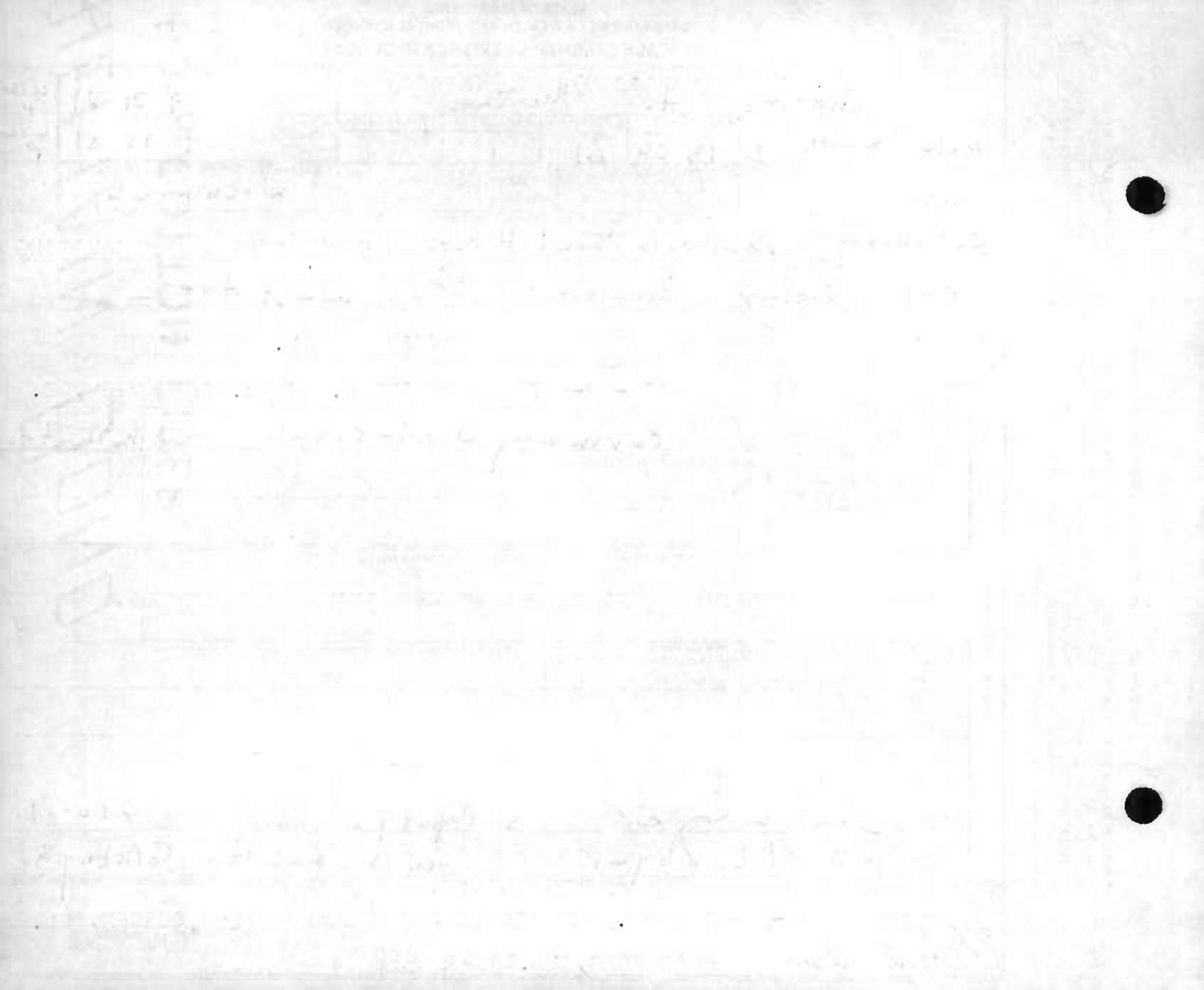


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24890					
1. DECEASED NAME (TYPE OR PRINT)				(CHARLES) (HARRISON) (MEGEE) Charles H. McGee				2a. DATE KNOWN MONTH DAY YEAR IF ESTIMATED 9 21 1981									
3. SEX Male				4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR 2 13 20 61 YRS.				6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 21 1981					
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS Peninsula Health Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACTOR				12b. KIND OF BUSINESS OR INDUSTRY EXCAVATING					
13a. STATE Del				13b. COUNTY Sussex				13c. CITY OR TOWN Ocean View				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS West Ave.			
14. FATHER'S NAME FIRST LEROY				MIDDLE				LAST MESEE				15. MOTHER'S MAIDEN NAME FIRST MATTIE		MIDDLE L.		LAST MESEE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES WWII				16c. ADDRESS 222-09-0473				17. INFORMANT MADELINE E. MESEE, OCEAN VIEW, DE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
ACTUAL SIGNATURE <u>Earl L. Royer</u>												DATE SIGNED <u>9-22-81</u>					
EXAMINER'S NAME (TYPE OR PRINT)				EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS <u>409 Camden Ave. Salisbury Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 9-24-81				23c. NAME OF CEMETERY OR CREMATORIUM ST. GEORGES CEMETERY				23d. LOCATION CITY OR TOWN CLARKSVILLE SUSSEX, DEL.					
24. FUNERAL DIRECTOR <u>Otto J. Nelson</u>				ADDRESS <u>FRANKFORD, DEL. 19945</u>				25a. DATE REC'D. BY REGISTRAR SEP 25 1981				25b. REGISTRAR'S SIGNATURE <u>Janice Jan Martin</u>					
BP _____																	
DHMH - 17 (VR A15 ME (5)) 15M 2/80																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G561 11/4/81r STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24891

1- STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

Troyne II ANTONIA McGlothen

2a. DATE KNOWN MONTH DAY YEAR
OF ESTI- DEATH MATED 9 22 1981
M

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR6. AGE (IN YEARS
LAST BIRTHDAY)7. IF UNDER 1 YR.
MONTHS DAYS8. IF UNDER 24 HRS.
HOURS MIN:2c. DATE
MONTH DAY YEAR
PRONOUNCED
DEAD2d HOUR
7:45 a.m.

Male

Black

2 8 81

YRS.

9 22 1981

M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Wicomico County,

MD.

10. CITY OR TOWN OF DEATH

Salisbury

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Peninsula General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

N/A

12b. KIND OF BUSINESS
OR INDUSTRY

13a. STATE

MARYLAND

13b. COUNTY

WICOMICO

13c. CITY OR TOWN

MARDELA SPRINGS

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS

ROUTE #1, BOX 150

14. FATHER'S NAME

TROY

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

TERRI

HAYMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

TERRI HAYMAN

SAME AS ABOVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Sudden Infant Death Syndrome

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7980

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF(b)
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

P.M.

19

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy , Inspection , Inquiry , and in my opinion

death resulted from:

Natural causes , Accident , Suicide , Homicide , Undetermined manner 22b. ACTUAL
SIGNATURETITLE (SPECIFY)
M.D. Deputy Chief MEDICAL EXAMINER

DATE SIGNED 9/23/81

EXAMINER'S NAME
(TYPE OR PRINT)

Thomas D. Smith, M.D.

III Penn St.

Balto., MD.

ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

9/26/81

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

SHARTOWN WICOMICO MARYLAND

24. FUNERAL DIRECTOR
NAME

Rt. #2, Jersey Rd.

25a. DATE REC'D. BY REGISTRAR

JOLLEY MEMORIAL CHAPEL

SALISBURY, MARYLAND

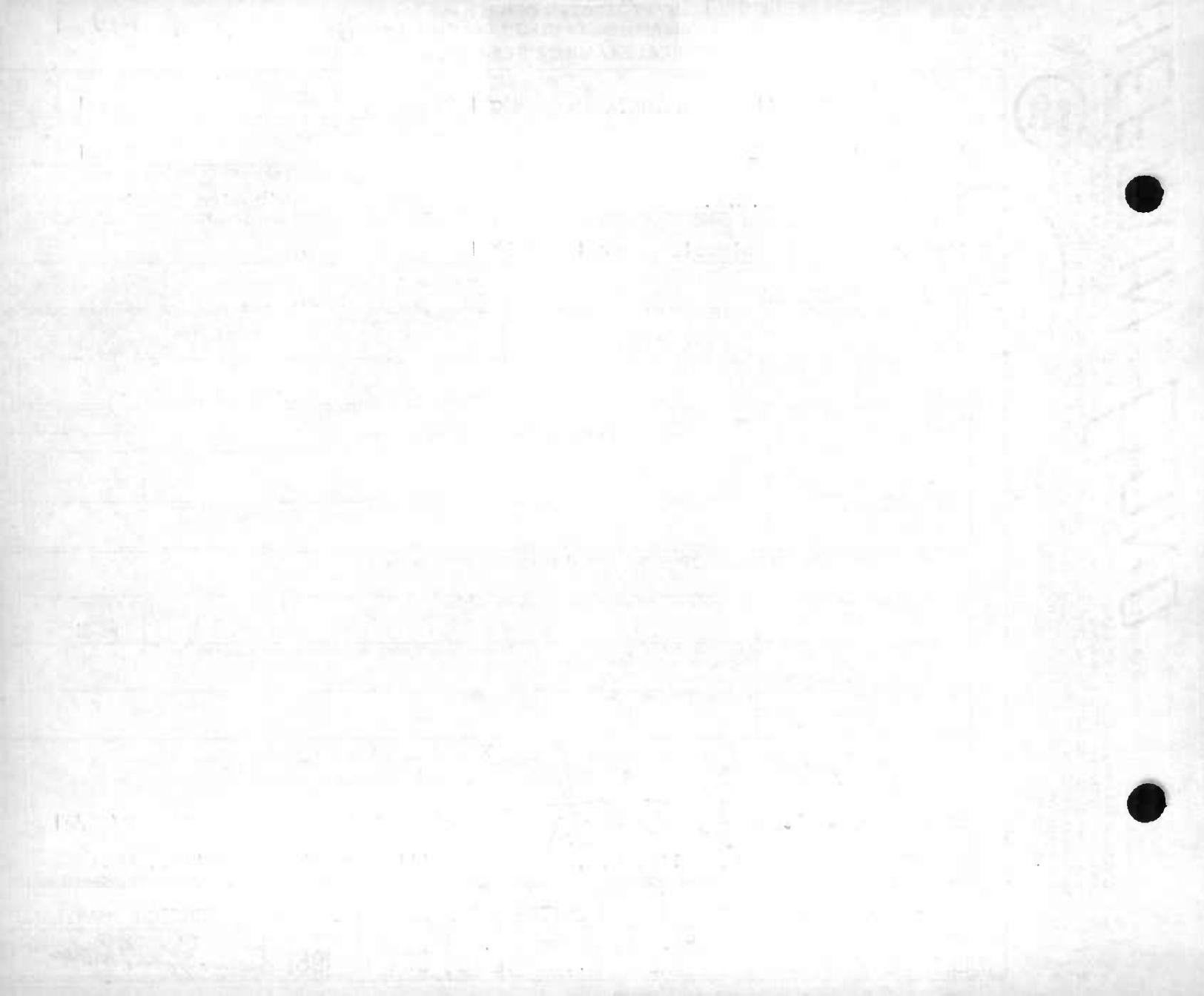
25b. REGISTRAR'S SIGNATURE
Erances Jean Harten

BP _____

DHMH-17

VRA15ME(5)

15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. File 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			SEPTEMBER 10, 1981 10:05 AM											
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
FEMALE			WHITE			4-12-16			65								
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS					
OHIO			USA						Wicomico								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital									CLERK				GOV'T.	
13a. STATE			13c. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			MD.					
MD			WOR			D.CITY			ISLE OF WIGHT T.A.								
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS					
GUY			TONY			ELIZABETH DURRIO			299-01-2428			LEO T. McKENNA Ocean City					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO												hypertension					
5722																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF											
			(c)			DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED AT WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>8/31</u> , 19 <u>81</u> , to <u>9/10</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8/31</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
W BEN HORNER MD															9/10/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									KAY AVE SALISBURY MD. 21801					
CREMATION			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE					
CREMATION			9-12-81			DELMARVA CREM. LEAVES, SUSSEX DE.											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
ULLRICH FUNERAL HOME BETHLEHEM, MO.						SEP 16 1981			THOMAS JAMES HARTER								

Indigofera heterophylla

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificat has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be paged at once.

MEDICAL CERTIFICATION

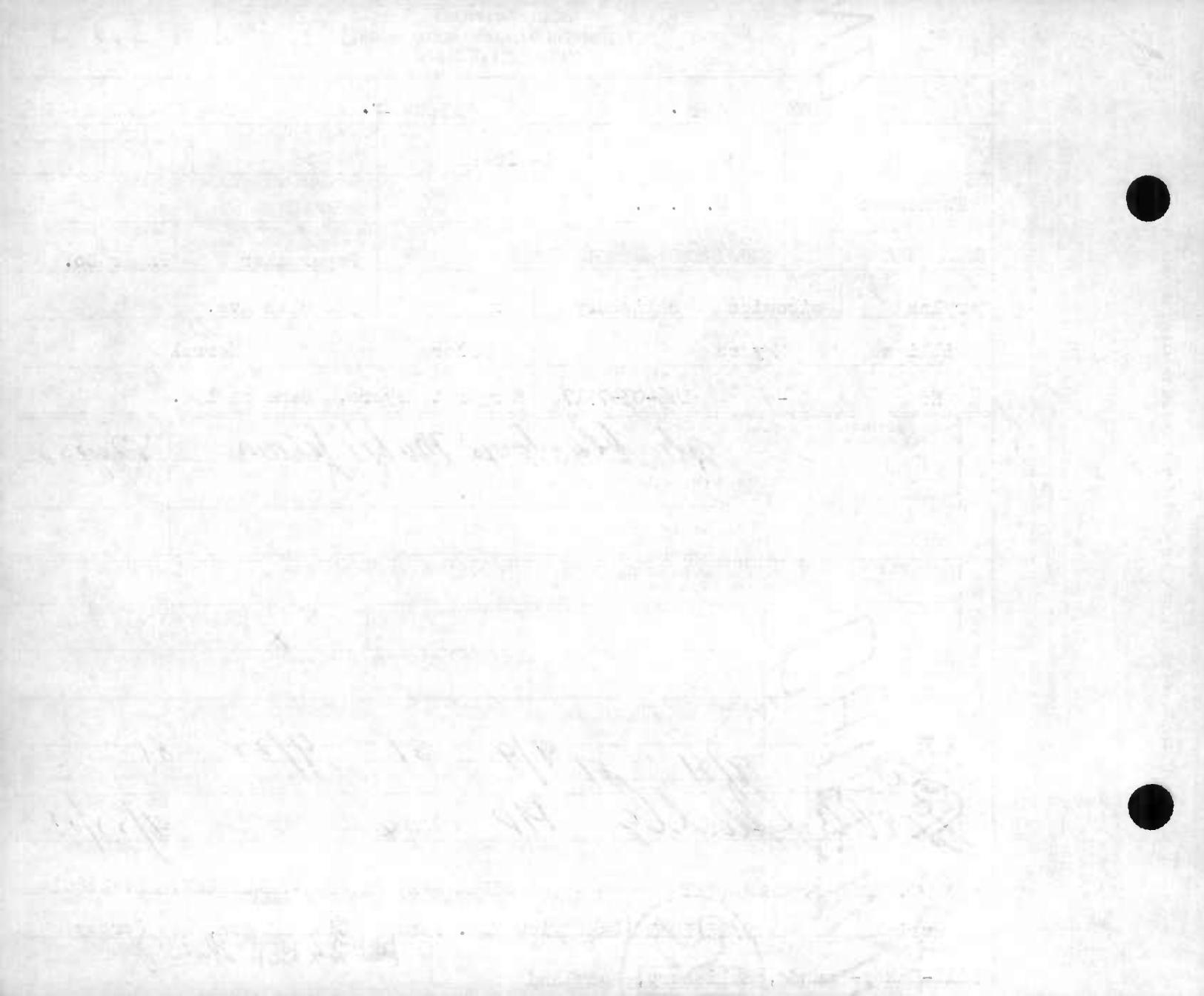
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 1 2 4 8 9 3

11. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
ROY L. MEYERS SR.						9---22-1981				5:45 a.m.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 1 - DAY 26 - YEAR 12		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE Tennessee		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO					
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Papermaker		12b. KIND OF BUSINESS OR INDUSTRY Paper Co.			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 320 Glen Ave.			
14. FATHER'S NAME FIRST William		MIDDLE Meyers		LAST		15. MOTHER'S MAIDEN NAME FIRST Flora		MIDDLE Herrel LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		16c. SOCIAL SECURITY NO. 146-03-7717		17. INFORMANT Margaret Meyers, Same as 13e.		ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1919 glioblastoma multiforma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first 1919		DUE TO OR AS A CONSEQUENCE OF (b) _____									
		DUE TO OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 9/9/81 to 9/22/81 , that (I) (we) lost the deceased alive on 9/9/81 and did not view the body after death.											
22b. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22c. SIGNATURE Dr. Earl M. Beardsley (SEE PHYSICIAN'S NAME (TYPE OR PRINT))		22d. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. ADDRESS CIVIC AVE, RT 50, SALISBURY, MD 21801				22f. DATE SIGNED 9/22/81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/25/1981		23c. NAME OF CEMETERY OR CREMATORIAL Lake View Mem. Park		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury, Maryland						25a. DECEASED DIED BY REC'D DATE SEP 24 1981		25b. REGISTRAR Miss J. [Signature]		SIGNATURE 24	
DHMH - 16 50M 1/B1 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 24894			
1 - STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Pearl Ann Miller						September 14 1981				6:00 P.M.			
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS				
Female			White		Oct. 8, 1911	69			IF UNDER 24 HRS MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia			USA					Wicomico MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital		Seamstress			Shirt Company					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 4, Johnson Road			
14. FATHER'S NAME James			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Clarcey			MIDDLE	LAST	Vance			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO 215-26-4864		17. INFORMANT Mr. Foster Miller (husband) same as 13			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { b) <u>septicemia</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>septicemia</u> <u>acute infection</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>diabetes mellitus</u> <u>cerebral vascular accident</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>diabetes mellitus</u> <u>cerebral vascular accident</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept 3 1981 to Sept 14 1981, that (I) (we) last saw the deceased alive on Sept 14 1981, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22e. DATE SIGNED 7/14/81			
22b. SIGNATURE Rodney A. Wenrich			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH			22e. ADDRESS KAY Ave., Salisbury, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/17/81		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Cemetery Gardens, Salisbury, Wic., Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 17 1981			25b. REGISTRAR'S SIGNATURE Pamela DeWitt							

Estimativa

Ley de la Cuenca del Río Grande

1970

2-12



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 4 8 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			Roy		MOORE	September 9, 1981				5:30 AM		
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		
Male			Cauc.	Month Day Year Apr 6, 1916		65				IF UNDER 24 HRS		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				MONTHS DAYS HOURS MIN.	
Delaware			USA									
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) maintenance work				12b. KIND OF BUSINESS OR INDUSTRY town of Delmar	
13a. STATE Delaware			13c. CITY OR TOWN Sussex		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 109 State St.				MD.	
14. FATHER'S NAME FIRST unknown			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Lizzie		16. ADDRESS 19956 Madeline Wingate, Locust St. Laurel Del				LAST Moore	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 222 07 3790		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			carcinoma of the lung									
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			DUE TO, OR AS A CONSEQUENCE OF (b)									
			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Nancy W. Tustin, M.D.			DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/12/81		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN Laurel		COUNTY Sussex		STATE Delaware	
24. FUNERAL DIRECTOR NAME Homer L. Disharoon box 678 Laurel Del 19950			ADDRESS SEP 14 1981 Frances Jan Nathan				REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

4

1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the medical examiner's office within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24896

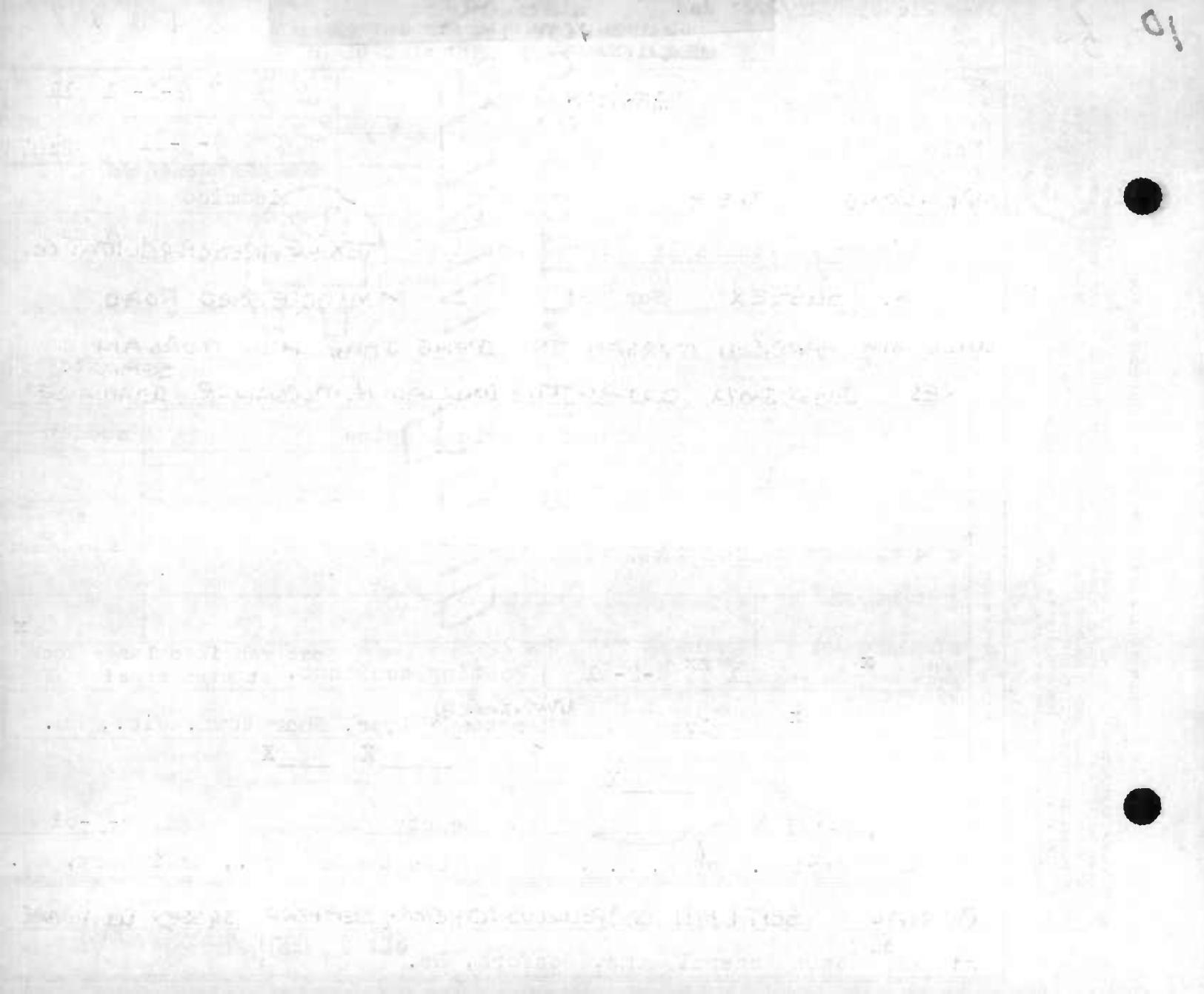
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
THURMAN Guy					Moore	9-12-81				1:35 PM			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male			White	2 24 '07			74 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			Wicomico MD.	
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Wicomico MD.	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital			Construction Foreman - Electric							
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
MD.			Wicomico	Salisbury				1203 Robert Street					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
			Guy		Moore	FIRST Annie			MIDDLE Gertrude			LAST Harding	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			1929-1935			217-10-2805			Mrs. Louise Moore (wife) same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Prostatic Cancer			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)										
			(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.													
22b. SIGN		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
Joseph A. Grasso MD								9/13/81					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			1300 S. Division St Eat Smis								
Joseph A. Grasso													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/81		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Mem. Gardens, Salisbury, Wic., Maryland			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
					SEP 15 1981			Thomas J. Nathan					
BP _____													
DHMH-16 50M 1/81 (VRA 15, 4)													

Indication of signed signature

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR FILING IN YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10 5		Item 21c G560 10/2/81 dad		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		1 24897			
FOR 1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		REG. NO.			
		ROBERT		HARRISON		MORGAN					
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS MONTH DAY YEAR LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Male		White		7 22 46		35 yrs.					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. STREET ADDRESS		14. KIND OF BUSINESS OR INDUSTRY	
MARYLAND		U.S.A.		Peninsula General Hospital		TEXILE ARENA APPENDLINT CO.		MIDDLEFORD ROAD			
15. CITY OR TOWN OF DEATH		16. STATE		17. COUNTY		18. CITY OR TOWN		19. STREET ADDRESS		20. KIND OF BUSINESS OR INDUSTRY	
Salisbury		De.		Sussex		Seaford		MIDDLEFORD ROAD			
21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		22. FATHER'S NAME		23. MOTHER'S MAIDEN NAME		24. ADDRESS		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		WILLIAM HARRISON MORGAN JR.		IPENE JANE HILL MORGAN		SEAFORD, DE		Sudden			
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES		27. SOCIAL SECURITY NO.		28. INFORMANT		29. ADDRESS					
YES Jan 6 - Jun 12		222-36-3548		WILLIAM H. MORGAN JR.		DELAWARE					
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Fractured Cervical Spine									
PART 1 DEATH WAS CAUSED BY: 8319		IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
31. MEDICAL CERTIFICATION		32. DATE OF OPERATION		33. CONDITION FOR WHICH OPERATION WAS PERFORMED?				34. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
35. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		36. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 11 P.M. 9-2-81		37. HOW INJURY OCCURRED (ENTER THREE OR MORE WORDS OR PHRASES) Boat ran into large dock Boating accident. at high speed							
38. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		39. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river		40. LOCATION (WATER)				41. CITY OR TOWN Sharptown River, Sharptown, Wic., Md.			
42. I certify that I took charge of the remains described above, held an death resulted from: Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		43. TITLE (SPECIFY) M.D. Deputy		44. MEDICAL EXAMINER				45. DATE SIGNED 9-3-81			
46. ACTUAL SIGNATURE											
47. EXAMINER'S NAME (TYPE OR PRINT)		48. ADDRESS 409 Camden Ave., Salisbury, Md.									
49. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		50. DATE SEPT. 6, 1981		51. NAME OF CEMETERY OR CREMATORIAL ODAPELLUS CEMETERY SEAFORD				52. LOCATION CITY OR TOWN SEAFORD			
53. FUNERAL DIRECTOR NAME Painter Watson Funeral Home, Seaford,		54. ADDRESS Painter Watson Funeral Home, Seaford,		55. DATE FILED BY REGISTRAR SEP 9 1981				56. COUNTY SUSSEX DELAWARE			
BP _____											
DHMH-17 (VR A15 ME (5)) 15M 2/80											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	8	9	8
												REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			Blanche Ann Moseley						September 4, 1981			10:15 AM						
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
Female			White			March 21, 1904			77 YRS									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD						
Shamokin, Pa.			USA						Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital			Practical nurse												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Wicomico			Mardela						P.O. Box 204						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT (daughter) ADDRESS R.D. 1, Box 201A Mrs. Lillian Majors, Mardela, Md.						
Jacob Sayitsky			Bertha Sobolowsky			NO			220-28-4415A									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral Infarction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days						
4349																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b)												
						DUE TO, OR AS A CONSEQUENCE OF												
						(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/20/81 to 9/4/81, 1981, that (I) (we) last saw the deceased alive on 9/4/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/4/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			Salisbury, Maryland									
O. J. Burton, M.D.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/8/81			23c. NAME OF CEMETERY OR CREMATORIAL Mardela Cemetery			23d. LOCATION CITY OR TOWN Mardela, Wicomico, Maryland									
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR SEP 9 1981			25b. REGISTRAR'S SIGNATURE Dances Jean Harten									

Latin American literature

Studies

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR PERSONAL USE. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24899							
1- STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF EST. DEATH MATED			2b. MONTH DAY YEAR				
Wade R. Myer												9 22 1981			15 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. MONTH DAY YEAR		
Male		White		2 14 65			21			MONTHS		DAYS		9 22 1981			15 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH MD.												
DELAWARE		USA		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Wicomico												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Salisbury		Peninsula Gen'l Hosp		LABORER			Food Process.												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS									
DELAWARE		SUSSEX		Delmar			<input checked="" type="checkbox"/>			Sharptown Rd									
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			16. ADDRESS												
PAUL		A.		FRANCES			202			DELMAR, DE 19940									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
NO		—		221-44-1836 PAUL A. MYER -			Multiple trauma			Unknown									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) multiple trauma																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF { (b) } DUE TO, OR AS A CONSEQUENCE OF { (c) }																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0015 P.M. 9 22 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by Auto															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway		21f. LOCATION Rt 54 & Jersey Rd, Sussex Del															
22a. I certify that I took charge of the remains described above, held at death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <i>Earl L. Royer</i>		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 409 Camden Ave Salisbury Md			DATE SIGNED 9-22-81														
23a. BURIAL, CREMATION, REMOVAL METHOD		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			24a. LOCATION CITY OR TOWN												
Burial		Sep 24, 1981		Bridgeville			Bridgeville - Sussex - DE												
25a. FUNERAL DIRECTOR NAME		25b. DATE		25c. REGISTRAR			25d. REGISTRAR'S SIGNATURE												
Howard Hardisty		202 Louis St.		Bridgeville			Sep 25 1981			Frances Jean Nathan									



St. Albans, N.Y.

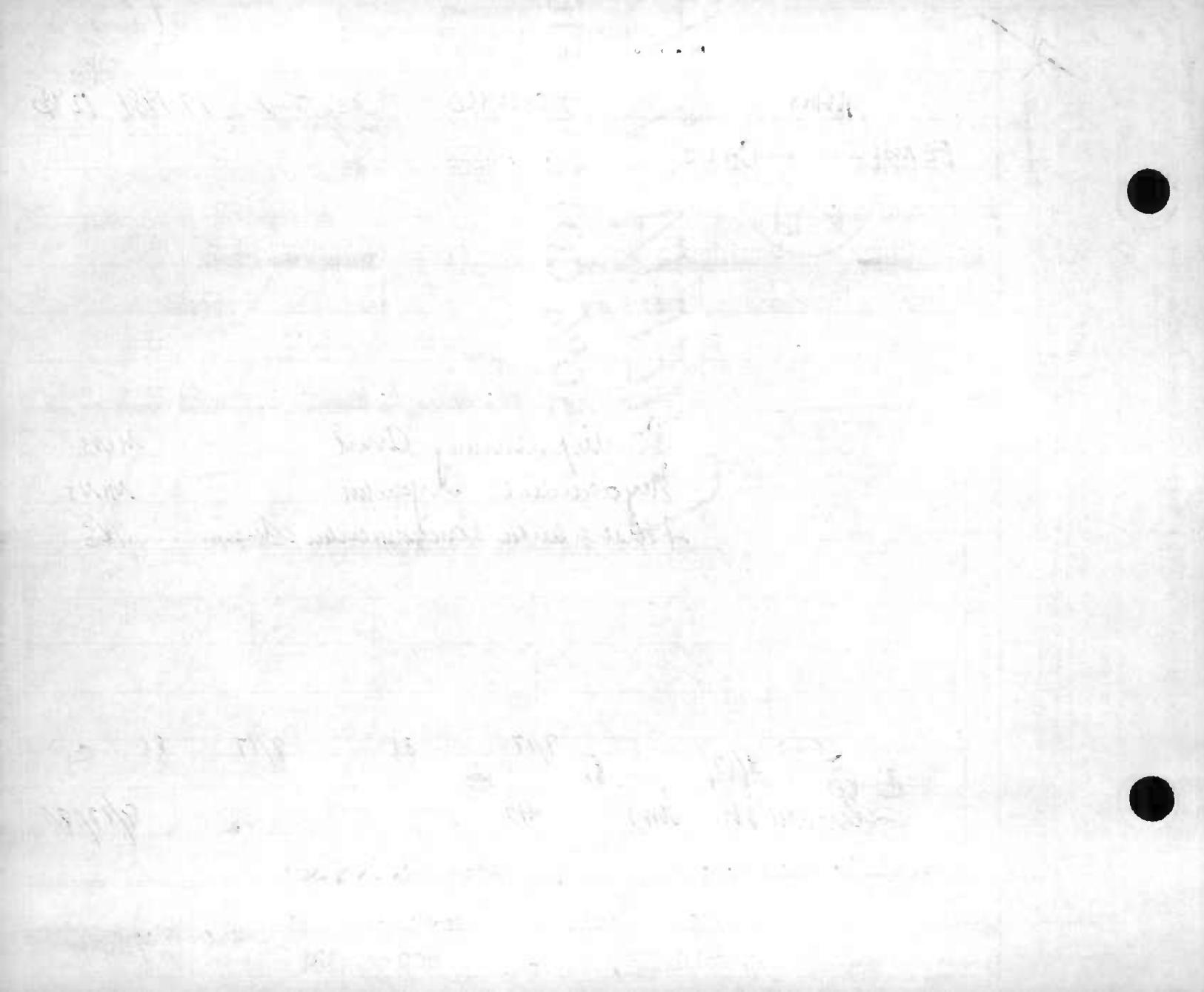
100-10888-938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	9	0
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
MARY			Jane	Oswald		September 17 1981					1981	12 45 PM					
2. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR							
FEMALE			Cauc.	Month Day Year Feb. 7, 1932			49			MONTHS DAYS HOURS MIN.							
BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Fruitland, Md.			USA						Wicomico			MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Salisbury			Peninsula General Hospital			Inventory Clerk											
13a STATE Maryland			13b COUNTY Wicomico			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 1509 Arbutus Drive								
14 FATHER'S NAME Louder			FIRST W.	MIDDLE .	LAST Brumley	15. MOTHER'S MAIDEN NAME Bertha			16b SOCIAL SECURITY NO. 220-28-2025			17 INFORMANT Mr. Bruce E. Oswald (husband) same as 13					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b SOCIAL SECURITY NO. 220-28-2025			17 INFORMANT Mr. Bruce E. Oswald (husband) same as 13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18 CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			18b DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction			18c DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease						MNS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												MNS					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) (his/hospital) attended the deceased from saw the deceased alive on 9/17 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We did) did not view the body after death.			22b SIGNATURE Donald M. Wood, M.D.			22c DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 9/17/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS Salisbury, Maryland														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE 9/20/81			23c NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens			23d LOCATION CITY OR TOWN Salisbury County Wicomico State Maryland								
24 FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland			25a ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland			25b DATE REC'D. BY REGISTRAR SEP 21 1981			25c REGISTRATION NUMBER 27-1000								



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

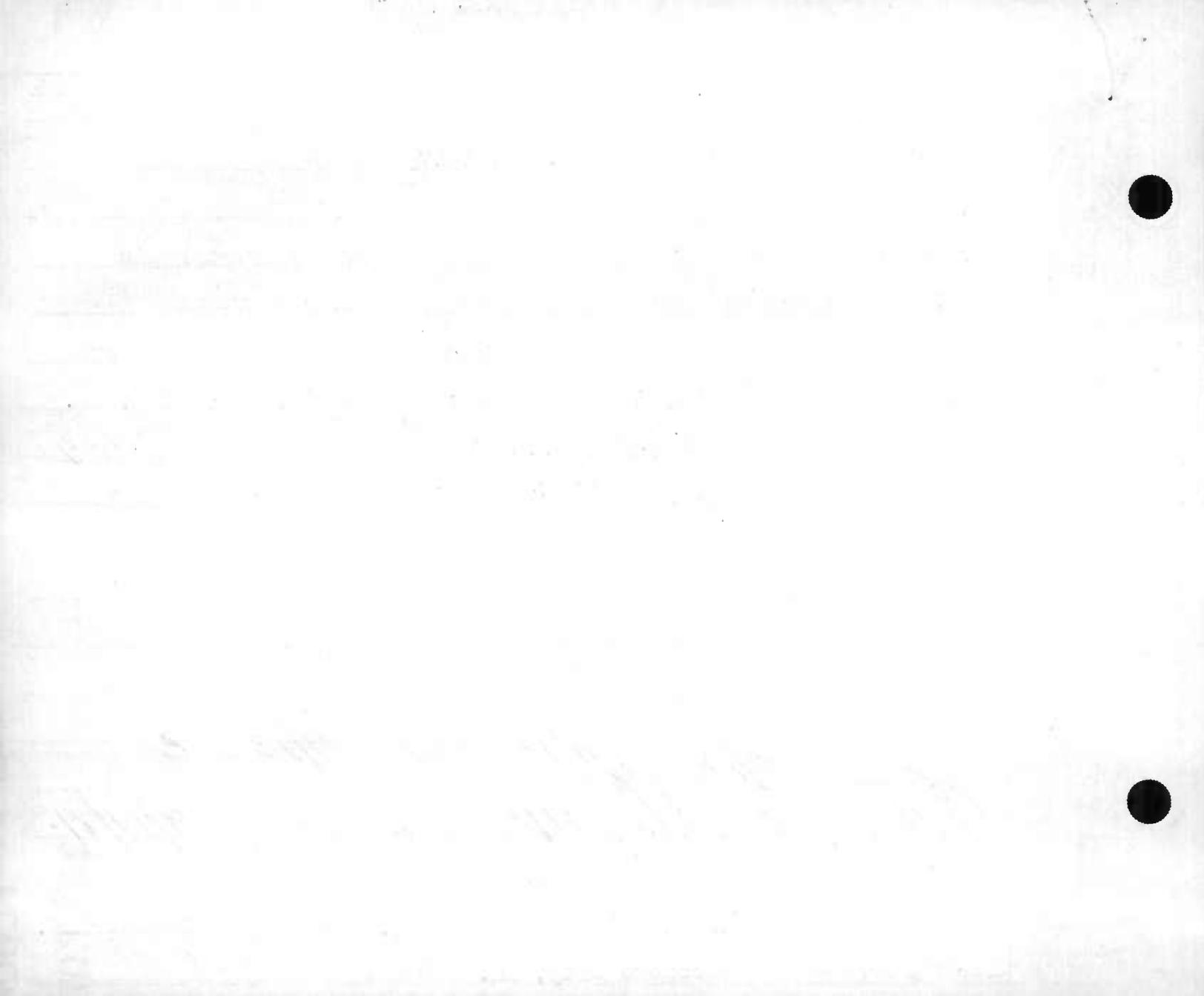
referred by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 81 24901					
1. DECEASED NAME (TYPE OR PRINT)			FIRST FRANK	MIDDLE P	LAST OUTTEN	2a DATE OF DEATH 9---13-1981	MONTH 9	DAY 13	YEAR 1981	2b HOUR 11:30 a.m.	
3. SEX male		4 RACE white		5. DATE OF BIRTH MONTH Feb. 16, 1917 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 64 yrs		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.					
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) auto body mechanic		12b KIND OF BUSINESS OR INDUSTRY					
13a STATE Maryland		13b COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Clarke Avenue			
14. FATHER'S NAME FIRST Frank		MIDDLE Otten		15. MOTHER'S MAIDEN NAME FIRST Cora		MIDDLE Lee		LAST Merritt			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 212-12-3669		17. INFORMANT Mildred Durham		ADDRESS 10 6th Street Pocomoke City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4340		DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Today.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22e. I certify that (I) (this hospital) attended the deceased from <u>9/16/81</u> to <u>9/13/81</u> , that (I) (we) last saw the deceased alive on <u>9/16/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (We) (did not) view the body after death.											
23e. ATTENDING PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.		24e. DEGREE M.D.		25e. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801		26e. DATE SIGNED 9/19/81					
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23c. DATE 9/16/81		23d. NAME OF CEMETERY OR CREMATORIAL First Baptist Cem.		23d. LOCATION CITY OR TOWN Pocomoke		23d. COUNTY Worcester		23d. STATE Md.	
24. FUNERAL DIRECTOR NAME Scott S. Nelson		ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR SEP 17 1981		25b. REGISTRAR'S SIGNATURE Doris O. Smith					
DHMH-16 20M (VRA 15, 4) 7/78											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

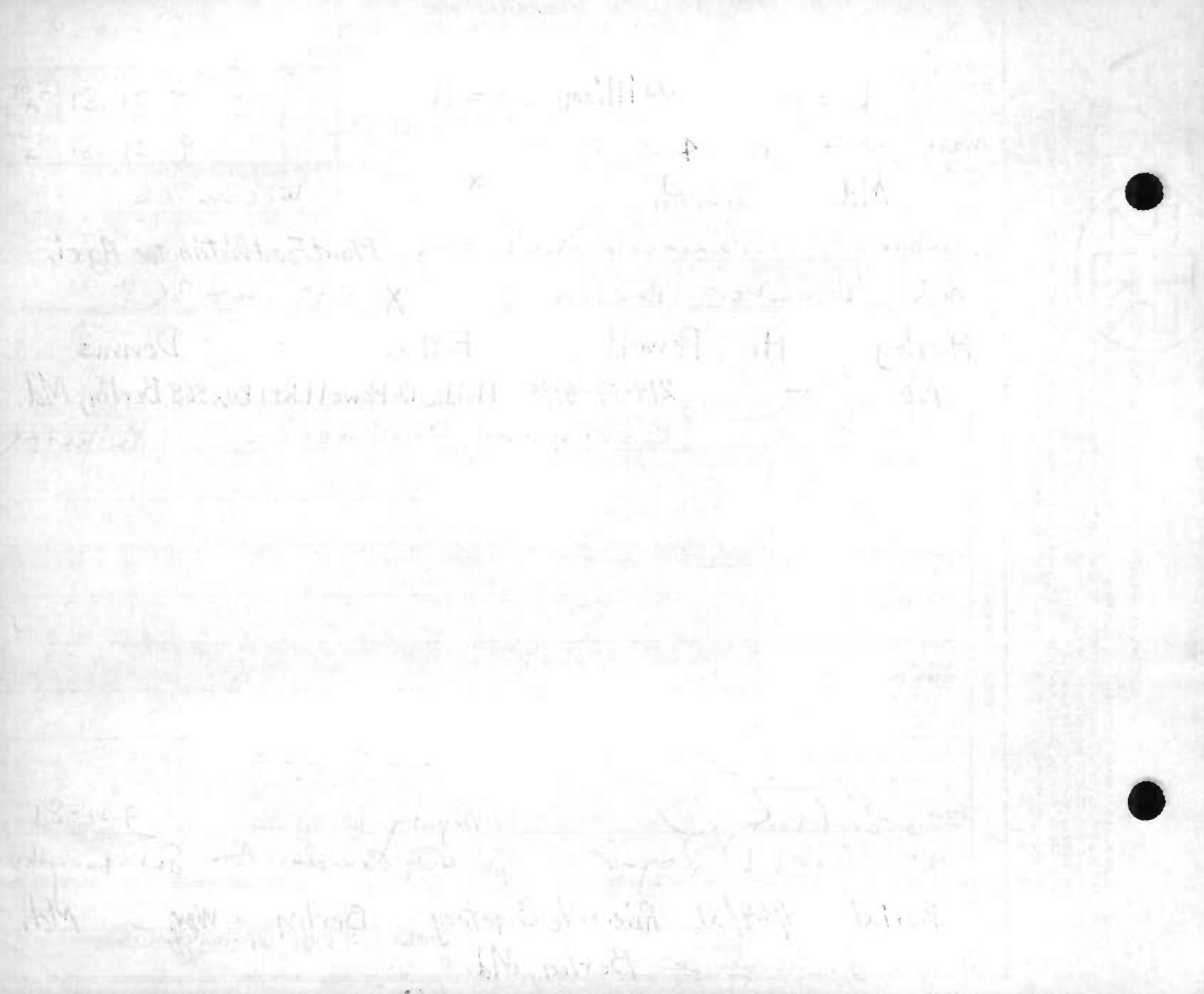
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 24902									
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		SEPT. 3, 1981			6:00 P.M.								
VIRGINIA						PEOPLES													
3 SEX Female			4 RACE Negro			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 74			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN								
7a. BIRTHPLACE COUNTRY North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico			YRS.								
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Va.			13b. COUNTY			13c. CITY OR TOWN Suffolk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 614 Ashley Ave.								
14. FATHER'S NAME FIRST Hennerson			MIDDLE R. C.			LAST Wood		15. MOTHER'S MAIDEN NAME FIRST Mary E. Davis			MIDDLE			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-14-5345			17. INFORMANT Mamie Haywood			ADDRESS R.F.D. 2, Bx. 51, Georgetown Maryland										
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular accident										BETWEEN ONSET AND DEATH									
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF (b) _____																			
DUE TO, OR AS A CONSEQUENCE OF (c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a hypertension																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) <u>this hospital</u> attended the deceased from 9/3, 1981, to 9/3, 1981, that (I) <u>most</u> saw the deceased alive on 9/3, 1981, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.																			
22b. SIGNATURE Rodney A. Wenrich										DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/3/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH			22e. ADDRESS KAY AVE SALISBURY MD 21801																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 09-10-81			23c. NAME OF CEMETERY OR CREMATORIAL Carver Memorial		23d. LOCATION CITY OR TOWN Suffolk			COUNTY		STATE Va.						
24. FUNERAL DIRECTOR NAME Clinton F. Stewart			ADDRESS West Rd. Salisbury, Md.							25. FILED BY MEDICAL REGISTRAR'S SIGNATURE OCT 8, 1981 Frances Jean Arthur									
DHMH - 16 50M 1/81 (VRA 15, 4)																			

50 50 40 07236 100

2000-2003 Food 3.8 increase

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24903										
1- STATE REGISTRAR																						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED			MONTH DAY YEAR			2b. HOUR 5:04 A.M.				
Lloyd			William			Powell						<input type="checkbox"/>			9 21 1981							
SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.										
Male		White		12 04 23			57 yrs.			MONTHS		DAYS		HOURS		MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD. Wicomico	
Md.			U.S.A.																			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury			Peninsula Inn Hotel									Plant Food Distributor Agri.										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
Md			Worcester			Berlin						RT 1 Box 368										
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME										
Hurley						H.			Powell			Ella						Dennis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			ADDRESS							
No			219-14-4118									Hilda D. Powell RT 1, Box 368 Berlin, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
															<input type="checkbox"/> YES <input type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Earl L. Roger</i>															TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 9-22-81							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 409 Camden Ave. Salisbury Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE								
Burial			9/24/81			Riverside Cemetery			Berlin			Md.										
24. FUNERAL DIRECTOR NAME			ADDRESS Anna J. Bushape Berlin, Md.									24e. DATE RECD BY REGISTRA 1981 SEP 26 1981			24f. SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

RECORDED

BP

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8124704

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Huby (Hughie) Thomas Purnell</i>						<i>September 25 1981</i>				<i>1:30 A.M.</i>			
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	# UNDER 1 YEAR		# UNDER 24 HRS				
<i>Male</i>			<i>Black</i>		MONTH <i>11</i> DAY <i>16</i> YEAR <i>38</i>	<i>43</i>	MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
<i>Berlin</i>			<i>USA</i>				<i>Wicomico</i>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<i>Salisbury</i>			<i>Peninsula General Hospital</i>						<i>TAXI Driver</i>		<i>Laborer</i>		
13a. STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
<i>MD</i>			<i>Worcester Berlin</i>				<i>Benepurent Rd-Berlin, MD</i>						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS					
<i>John</i>					<i>Purnell</i>	FIRST <i>Blanche</i>	MIDDLE	LAST <i>Derrickson</i>	<i>Briddellton Rd,</i>		<i>BERLIN, MD.</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
(NO)					<i>Ruby Purnell</i>		2 days						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			<i>Upper Gastrointestinal Bleeding</i>						10 years.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) <i>Cirrhosis of Liver</i>													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
					<i>19 81</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>9-25</i> 19 <i>81</i> to <i>9-25</i> 19 <i>81</i> , that (1) (we) last saw the deceased alive on <i>9-25</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I will (did) not) view the body after death.									22e. DATE SIGNED				
22b. SIGNATURE <i>Karen Morris</i>			22c. DEGREE <i>ms</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>9-25-81</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
<i>Burial</i>			<i>9-30-81</i>		<i>Evergreen</i>			<i>Berlin</i>		<i>Worc.</i>	<i>Md.</i>		
24. FUNERAL DIRECTOR <i>Jolley Mem. Chapel-Rt 2 SALISBURY, MD</i>									25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Janes Jan Martin</i>				

oaksonit

Indigofera heterantha

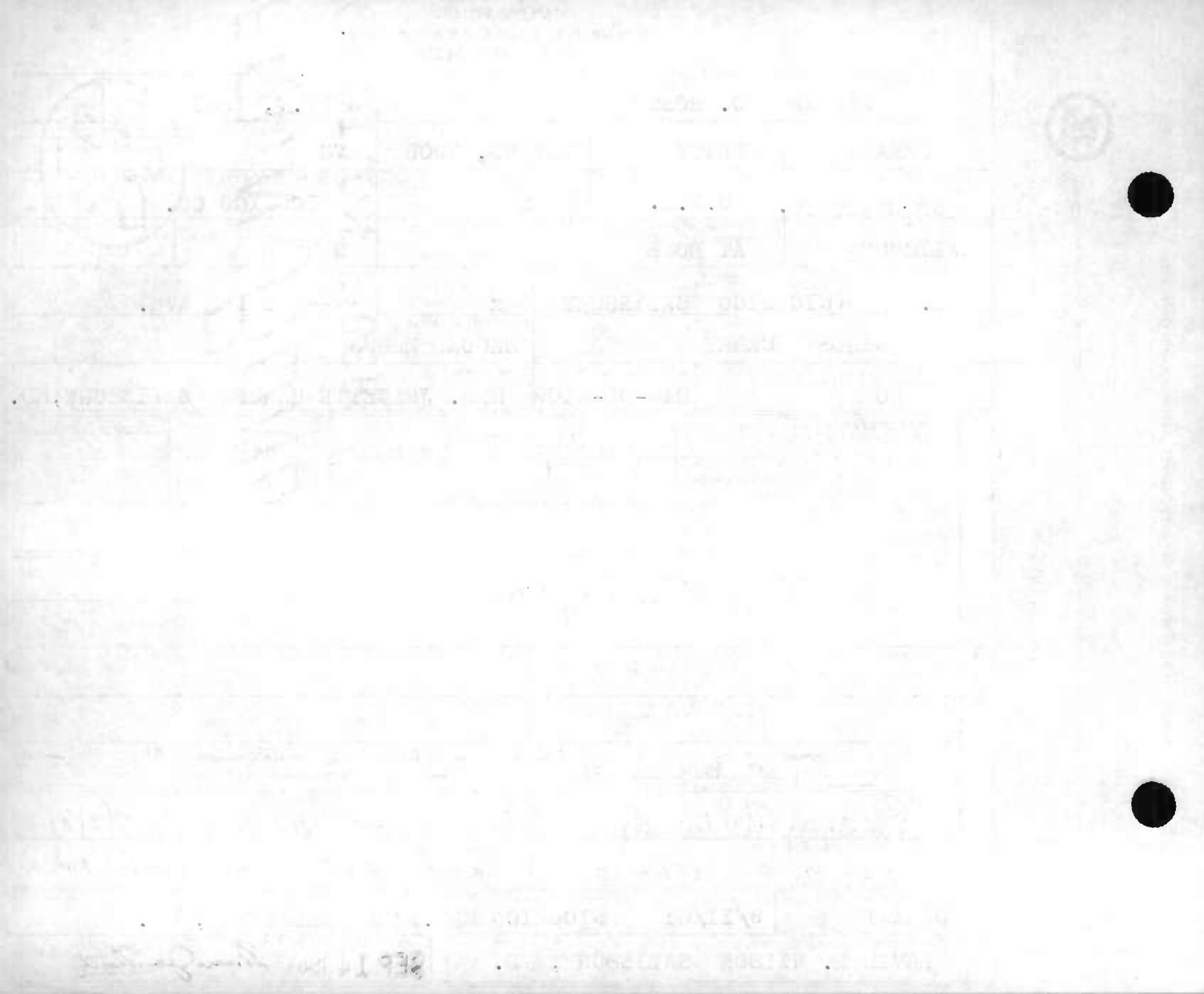
Saltdeprived

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 31 24905			
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			LILLIAN C. ROSS						SEPT. 7, 1981						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
FEMALE			WHITE			MAY 29, 1905			76			YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
SOMERSET CO.			U.S.A.						WICOMICO CO.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
SALISBURY			AT HOME			NON									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
MD.			WICOMICO			SALISBURY						1013 TYLER AVE.			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
SINDEY CAREY						MAUDE HOBBES									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
NO			219-05-8409			MRS. JEANETTE HARMON			SALISBURY, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4960</u> , <u>chronic obstructive pulmonary disease</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) _____ (c) _____															
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>diabetes mellitus, hypertension</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>July</u> , 19 <u>81</u> , to <u>Dept. 7</u> , 19 <u>81</u> , that (I) <u>was</u> lost saw the deceased alive on <u>2 June</u> , 19 <u>81</u> , and that in (my) <u>no</u> opinion death occurred on the date and hour and from the causes stated (I) <u>did not</u> view the body after death															
22b. SIGNATURE <u>Rodney A. Wenrich</u>			DEGREE MD.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/8/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RODNEY A. WENRICH</u>			22e. ADDRESS KAY AVE. SALISBURY MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/II/81			23c. NAME OF CEMETERY OR CREMATORIAL WICOMICO MEM. PARK			23d. LOCATION CITY OR TOWN SALISBURY, MD.			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME LEVIN R. WILSON			ADDRESS SALISBURY, MD.			25a. DATE REC'D. BY REGISTRAR SEP 14 1981			REGISTRAR'S SIGNATURE <u>James Jan Martin</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3	1	2	4	9	0	6					
1 - FOR STATE REGISTRAR			REG. NO.																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
WILLIAM T. SAUERHOFF												September 11, 1981						2:15A.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS								
Male			White			MONTH 7 YEAR 1896			85			YEARS			MONTHS DAYS HOURS MIN								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Bethel, Delaware			USA						Wicomico														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital												retired - auto dealer								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			Rt. 1, Cherry Hill Lane								
Md. Wicomico			Salisbury																				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.												17. INFORMANT			ADDRESS		
FIRST William			LAST Jackson			FIRST Ruth			MIDDLE			221-01-7281			Mrs. Margaret J. Sauerhoff (wife) same as			Eskridge					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW I			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
						Metastatic Carcinoma												13 months					
1536 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						b). DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Right Colon												years					
						c). DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																							
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			19d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			19e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR F.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-10-81 19 to 9-11-81 19 that (I) (we) last saw the deceased alive on 9-10-81 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we died) (did not) view the body after death.																							
22b. SIGNATURE						22c. DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			DATE SIGNED					
Earl L. Royer, M.D.																		9-11-81					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/13/81			23c. NAME OF CEMETERY OR CREMATORIUM Odd Fellow Cemetery			23d. LOCATION CITY OR TOWN Laurel, Sussex, Delaware			COUNTY			STATE								
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME			ADDRESS Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR SEP 14 1981			25b. REGISTRAR'S SIGNATURE Anne J. [Signature]														

calculus

standard basis - coordinate functions defined on manifold

each local coordinate chart

CPS - 10 - 152

bottom

middle of page

right

left, right to middle

x

TO HOSPITAL ATTENDING PHYSICIAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24907

REG NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
William E.					Schoolfield	September 2, 1981				9:30 AM		
3. SEX		RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		
M		B	MONTH	DAY	YEAR	54				MONTHS	DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Md		U.S.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico			MONTHS	HOURS
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MIN	
Salisbury		Peninsula General Hospital			LABORER			SEAFOOD			MD	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Md		Somerset	Somerset			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RT-1-Box 165			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
North				Schoolfield	Cecile					Cropper	5 hrs	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			2 days	
No					Annie L. Schoolfield						2 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) Cardiac arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) increased intracranial pressure												
DUE TO, OR AS A CONSEQUENCE OF (c) intracerebral hemorrhage 20 to hypotension												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-31 1981 to 9-2 1981, that (I) (we) last saw the deceased alive on 9-2-1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			3 Medical Center Salisbury MD 21801			9-2-81				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial		9/7/81	St James			Pocomoke			Wicomico		MD	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Anthony E. Ward Croft		MD			SEP 8 1981			James Van Harten				

26 March 41

3 miles N.

cont'd

2.0

b165

Varied sparrow, Indigo bunting, American
robin, House sparrow

House sparrow

43102-171

varied sparrow

b166

varied bunting

b167

varied bunting

b168

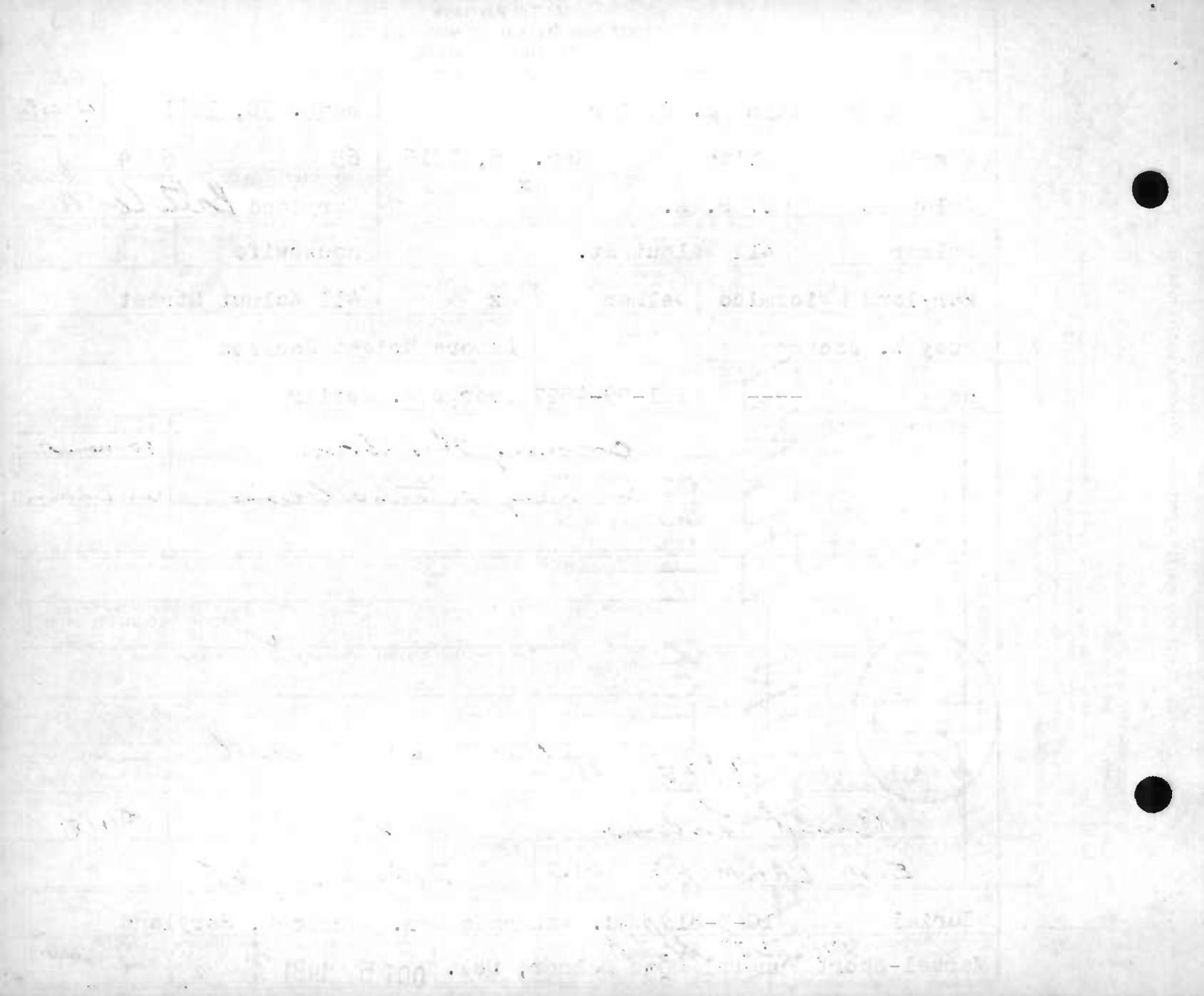
Varied sparrow, Indigo bunting, House sparrow

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8124908	
1 - STATE REGISTRAR			REG. NO.										
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Gwendolyn J. Sevier						Sept. 30, 1981						4:30 PM	
3. SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White		Mar. 26, 1916			65			YRS 6 4		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10a. PLACE OF DEATH Delmar		
Delaware			U. S. A.					Wicomico Co. Del.			Wicomico Co. Del.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Delmar			411 Walnut St.						Housewife				
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Delmar		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 411 Walnut Street			
14. FATHER'S NAME FIRST Huey W. Jackson			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME LeDora Wright Jackson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. no		17. INFORMANT George F. Sevier			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			coronary thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) coronary arteriosclerosis						unknown				
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/5/1967 to death, 19, that (I) (we) last saw the deceased alive on 9/28/1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Curt Larmore			DEGREE						22c. DATE SIGNED 10/1/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. M. LARMORE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22e. ADDRESS Delmar, Del.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-3-81			23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cem.			23d. LOCATION CITY OR TOWN Hurlock, Maryland				
24. FUNERAL DIRECTOR NAME Marvel-Short Funeral Home			ADDRESS Delmar, Del.						25a. DATE REC'D. BY REGISTRAR OCT 5 1981			25b. REGISTRAR'S SIGNATURE James J. Martin	



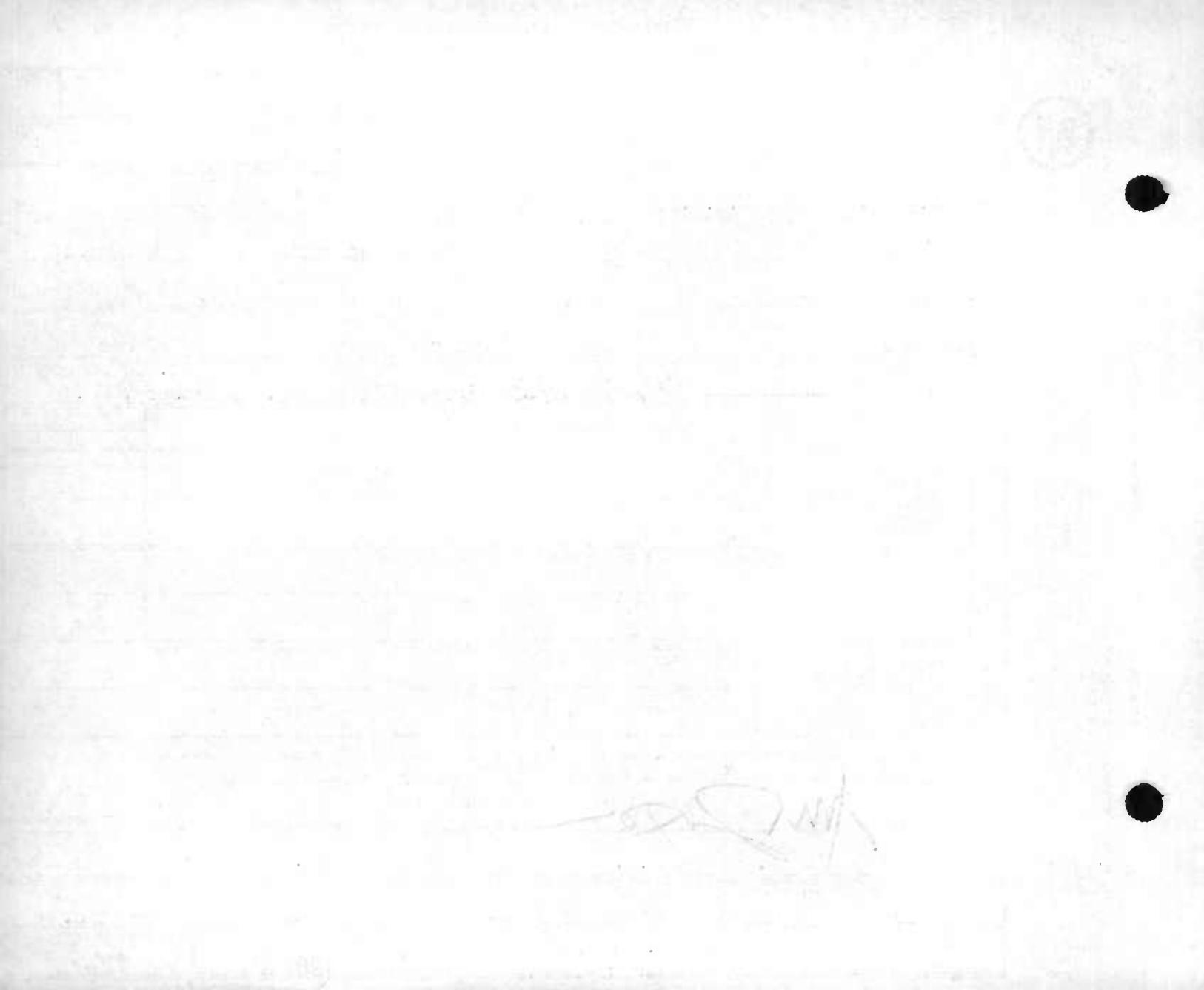
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

Items #18a-22a Film G561 11/4/81 rc STATE OF MARYLAND
FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REGISTRAR

24909

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
SYLVIA Whitney SHOCKLEY						<input checked="" type="checkbox"/>	9	17	19	81		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR		
female	negro	12 11 60	20 yrs	MONTHS	DAYS	HOURS	MIN			9:55 P.M.		
7a. BIRTHPLACE (STATE OR * FOREIGN COUNTRY) Salisbury, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) domestic			12b. KIND OF BUSINESS OR INDUSTRY housewife				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 413 Hearne Lane						
14. FATHER'S NAME FIRST Sylvester		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Mildred			MIDDLE	LAST	Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-70-6463			17. INFORMANT Mildred Whitney			ADDRESS Rt. #4 Johnson Rd. Salisbury, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Focal myocarditis											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4290 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>											DUE TO, OR AS A CONSEQUENCE OF	
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o.)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			DATE SIGNED 9-18-81				
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.			ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/26/81		23c. NAME OF CEMETERY OR CREMATORIAL House of Jacob Cemetery		23d. LOCATION CITY OR TOWN Princess Anne Somerset Md.		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS Rt. #2, Jersey Road		25a. DATE REC'D. BY REGISTRAR Oct 8 1981		25b. REGISTRAR'S SIGNATURE Jolley Memorial Chapel Salisbury, Md.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 24910		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
WILLIAM EARL SMALL						9/23/1981			11	24		11 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White		Month Day Year Oct. 2, 1893		87			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Virginia			USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury			Peninsula General Hospital		retired salesman									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Worcester		Pocomoke		NO			616 Walnut Street				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
William Henry Small			Ella											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no			212-03-3488		Jessie R. Small		6 months			616 Walnut Street Pocomoke City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO, OR AS A CONSEQUENCE OF														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>AGE RELATED CARDIO-VASCULAR DISEASE</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
9/10/81			18 - PALLIATIVE BY PASS			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 8-31 1981 to 9-23 1981, that (I) (was) lost saw the deceased alive on 9-23 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED					
John M. Blaxom III M.D.									9-23-1981					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23d. LOCATION CITY OR TOWN COUNTY		
Burial			MEDICAL CENTER, SALISBURY, MD.			First Baptist Cem. Pocomoke Worcester, Md.			9/25/81			21881		
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE RECD BY REGISTRAR								
Scott S. Nelson			Pocomoke City, Md.			Sep 29 1981								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify me.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 2 4 9 1 1

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Aileen M. E.</i>					<i>Smith</i>	<i>September 23 1981</i>				<i>9:00 AM</i>	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS				
female	white	MONTH	DAY	YEAR	67	MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH	
<i>Washington, DC</i>	<i>U.S.A.</i>									<i>Wicomico</i>	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Salisbury</i>	<i>Peninsula General Hospital</i>					<i>Employee</i>			<i>I.R.S.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
<i>MD</i>	<i>Baltimore</i>	<i>Baltimore</i>			<i>7005 Gaymount Road</i>						
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		16. ADDRESS			LAST		
<i>Matthew</i>	<i>Thomas</i>		<i>Morrison</i>	<i>Bridget</i>		<i>Mr. Robert M. Smith</i>			<i>O'Toole</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. <i>270-34-8299</i>			17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>Part I. DEATH WAS CAUSED BY</i>											
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>											
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac Arrest after subendocardial</i>					
						DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input type="checkbox"/> (in this hospital) attended the deceased from <i>9/13/81</i> to <i>9/23/81</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>9/22/81</i> and that <input type="checkbox"/> (in my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert M. O.</i>	DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/23/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Playboy Robert M. O.</i>	22e. ADDRESS <i>Box 49 Salisbury MD 21801</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial	<i>9/26/81</i>	<i>Lake View Mem. Park</i>			<i>Sykesville</i>		<i>Carroll</i>	<i>MD</i>			
24 FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Director</i>	25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
<i>8728 Liberty Rd., Randallstown, MD 21133</i>	<i>SEP 25 1981</i>			<i>Frances Jean Hartman</i>							

microscopic

Self-purifying Peninsular Gensuay Embayment

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #23b per phone call w/Fun.		STATE OF MARYLAND		8 1 2 4 9 1 2					
FOR Home 9/9/81 rc		DEPARTMENT OF HEALTH AND MENTAL HYGIENE							
1 - STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST					
RICHARD		LEE		Smith					
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		2d. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Male		BLACK		1	24	01	September	1981	14 AM
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
MT. VERNON, MD.		U.S.A.						IF UNDER 24 HRS HOURS MIN	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		RETIRED		WATERMAN			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MARYLAND		SOMERSET		PRINCESS ANNE				16 PINE KNOLL DRIVE	
14 FATHER'S NAME FIRST		MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
ARTHUR			SMITH	MATILDA			JONES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		---		217-16-9073		HATTIE SMITH		SAME AS ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY (IMMEDIATE CAUSE 1a) <u>Respiratory Arrest</u> <u>1850</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe emaciation, metastatic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Carcinoma prostate</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>COPD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24/81</u> to <u>9/7/81</u> , that (I) (we) last saw the deceased alive on <u>7/6/81</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>D. SAGGAR</u>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/7/81			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) D. SAGGAR		22f. ADDRESS 547-Riverside Drive Salisbury							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/13/81		23c. NAME OF CEMETERY OR CREMATORIUM ST. PAUL U.M. CEMETERY		23d. LOCATION CITY OR TOWN MT. VERNON SOMERSET MARYLAND			
24. FUNERAL DIRECTOR NAME		ADDRESS JERSEY ROAD		25a. DATE REC'D. BY REGISTRAR SEP 9 1981		25b. REGISTRAR'S SIGNATURE James J. Arthur			
TOLLEY MEMORIAL CHAPEL		SALISBURY, MARYLAND							

Permit to Release Information

Category

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 4 9 1 3		
										REG. NO.		
1- FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR		
I. DECEASED NAME (TYPE OR PRINT)			LAST			July 29, 1917			6 15 P M			
3. SEX Female			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan			7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10 IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a STATE Maryland			13c. CITY OR TOWN Somerset Princess Anne		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS RFD.					
14. FATHER'S NAME FIRST Floyd Oswald			LAST		15 MOTHER'S MAIDEN NAME FIRST Minerva Johnston			LAST				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 054-50-1532		17. INFORMANT William B. Stein, Princess Anne, Md.			ADDRESS				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 2° to										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) widely metastasized small cell lung Cancer												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/21/81 , to 9/26/81 , that (I) (was) lost saw the deceased alive on 9/21/81 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.										22b. DATE SIGNED 9/26/81		
22c. SIGNATURE Joseph A. Grasso			22d. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. ADDRESS 1300 S. Division St												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/3/1981		23c. NAME OF CEMETERY OR CREMATORIAL Northview			23d. LOCATION CITY OR TOWN Dearborn		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME James L. Hinman			ADDRESS Princess Anne, Md.		25. DATE REC'D. FOR REGISTRATION 08/11/1981			REGISTRATION NUMBER 1901				

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 1 2 4 9 1 4				
										REG. NO.				
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE	LAST	2. DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
		LEMUEL						STEWART	September 14, 1981					12 45 P.M.
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black			Month Day Year Sept. 11, 1903			78		MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.				
MARYLAND		USA						WICOMICO						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Salisbury, MD		Deer's Head Center						CARPENTER		RET.				
13a STATE MARYLAND		13b COUNTY DORCHESTER		13c CITY OR TOWN CORDTOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS RFD 2						
14 FATHER'S NAME JUNE		15 MOTHER'S MAIDEN NAME STEWART			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 217-54-5490		17 INFORMANT JAMES STEWART		ADDRESS CAMBRIDGE, MD.			
NO														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		respiratory failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					DUE TO, OR AS A CONSEQUENCE OF (b) COPD					4 yrs				
					DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary tuberculosis, class III, ASCVD</i>														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a I certify that in (this hospital) attended the deceased from August 6, 1981 , to September 14, 1981 . that we (we) last saw the deceased alive on September 14, 1981 , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.														
22b SIGNATURE <i>Nancy W. Tustin, M.D.</i>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 9/14/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M. D.		22e ADDRESS Deer's Head Center, Salisbury, MD 21801												
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE SEPT 14, 81			23c NAME OF CEMETERY OR CREMATORIUM UNION CHAPEL		23d LOCATION CITY OR TOWN CORDTOWN		COUNTY DOR. MD.		STATE			
24 FUNERAL DIRECTOR NAME <i>Tedrich C. Solari</i>					ST. CLAIR F. HOME CAMBRIDGE, MD.		25a DATE REC'D. BY REGISTRAR SEP 23 1981		25b REGISTRAR'S SIGNATURE <i>Jane Jas Martin</i>					

1. (1) I am satisfied

2. (2) I am not satisfied

3. (3)

4. (4) I am not very satisfied

5. (5) I am not at all satisfied

6. (6) I am not very satisfied

7. (7) I am not at all satisfied

8. (8) I am not very satisfied

9. (9) I am not at all satisfied

10. (10) I am not very satisfied

11. (11) I am not at all satisfied

12. (12) I am not very satisfied

13. (13) I am not at all satisfied

14. (14) I am not very satisfied

15. (15) I am not at all satisfied

16. (16) I am not very satisfied

17. (17) I am not at all satisfied

18. (18) I am not very satisfied

19. (19) I am not at all satisfied

20. (20) I am not very satisfied

21. (21) I am not at all satisfied

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If 16 cm 21 x moded or from 18 hours 220 inches

MEDICAL CERTIFICATION

**1 - FOR
STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24913

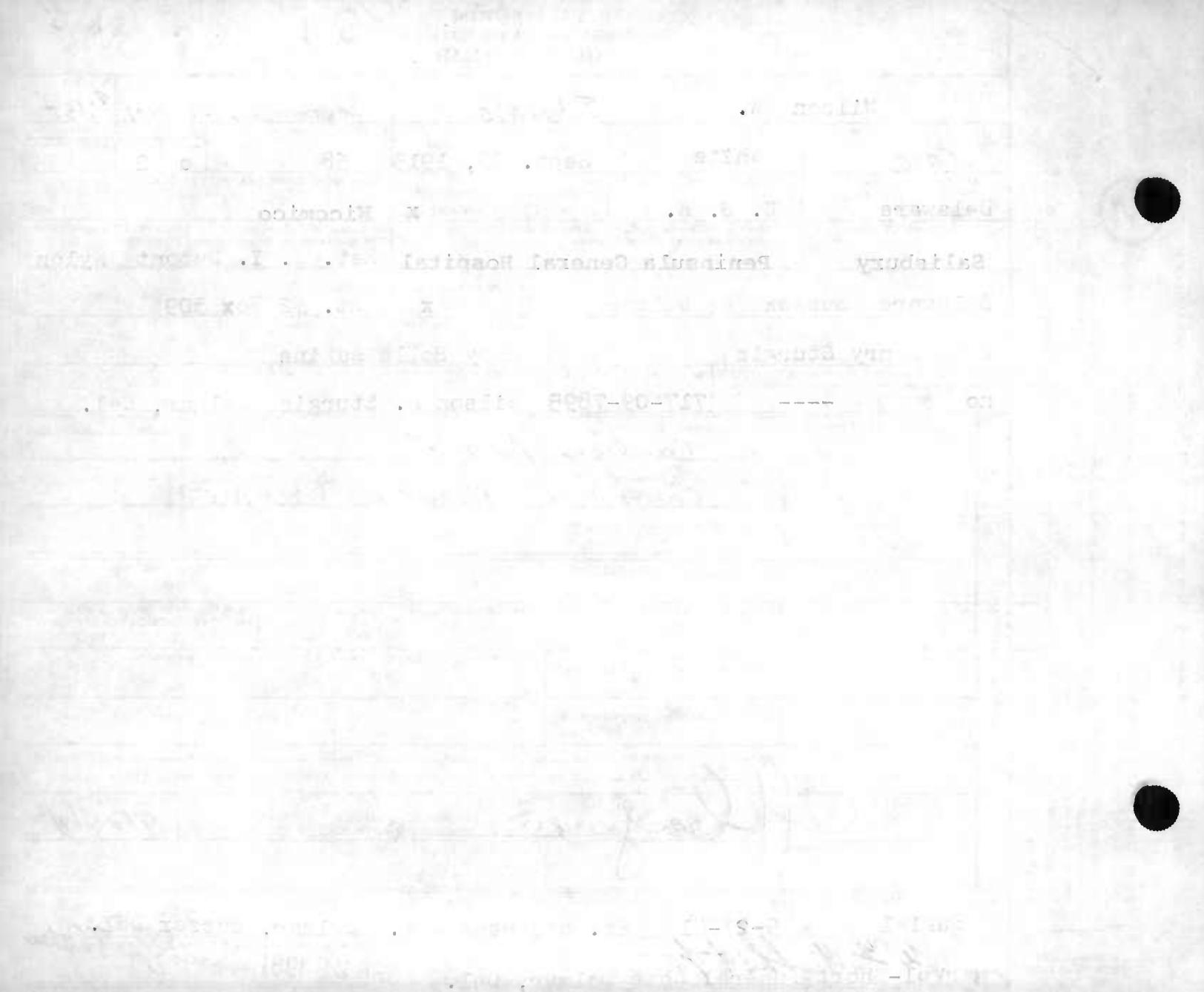
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Eleanor Marie STOEHRL						SEPTEMBER	2, 1981			11:42 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		White		July 1, 1915			66 YRS			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico						
Plainfield, N.J.		J. USA											
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital					12a. USUAL OCCUPATION Ex. Secretary			12b. KIND OF BUSINESS OR INDUSTRY Board of Education			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 6, Dagsboro Road			
14. FATHER'S NAME FIRST Joseph		MIDDLE Kearns		15. MOTHER'S MAIDEN NAME LAST Anna									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Mr. Eugène Stoehrle			ADDRESS (husband)			Lamp same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Santa Pulmonary Edema</u> 4039 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO OR AS A CONSEQUENCE OF } <u>Hypertensive Cardiovascular disease</u> (c) _____ } DUE TO OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)								
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22d. I certify that <input type="checkbox"/> (name of hospital) attended the deceased from the deceased alive on <u>9/2/81</u> to <u>10</u> and that in my <u>four</u> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I did) <input type="checkbox"/> (I did not) view the body after death.					22e. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22f. SIGNATURE					22g. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22h. PHYSICIAN'S NAME (TYPE OR PRINT)		22i. ADDRESS			22j. DATE SIGNED								
Clayton Raab, M.D.		Box 49 Salisbury MD			9/2/81								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		8/5/81		Hillside Cemetery			Plainfield, Union, N.J.						
24. FUNERAL DIRECTOR		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR					
HOLLOWAY FUNERAL HOME, Salisbury, Maryland					SEP 8 1981			Charles J. Holloway					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 9 1 0					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Wilson W.					Sturgis	September 25 1981						8:15 A.M.					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
Male			White		Sept. 23, 1913			68			MONTHS	DAYS	IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH								
Delaware			U. S. A.						Wicomico			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital									Ret. E. I. Dupont Nylon					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Delaware			Sussex		Delmar			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. #2 Box 309						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
John Henry Sturgis						Mary Belle Adkins											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. -----			17. INFORMANT			ADDRESS								
			717-09-7895			Wilson H. Sturgis Delmar, Del.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 4149 Cardiac Arrest																	
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED								
22f. PHYSICIAN'S NAME (TYPE OR PRINT)						22g. ADDRESS			9/13/81								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY					
Burial			9-27-81			St. Stephens Cem.			Delmar			Sussex Del.					
24. FUNERAL DIRECTOR NAME _____ ADDRESS _____			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. STATE								
Marvel-Short Funeral Home Delmar, Del.									SFP 29 1981			Tinae J. Farther					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												B 1 2 4 9 1 7						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Laura Beatten Tanswell												9-22-81				8:45 AM	8:45 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
FEMALE			WHITE			MONTH DAY YEAR			86			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Wicomico		MD.				
Maryland			U.S.A.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET ADDRESS						
Salisbury			RIVERWALK MANOR			Housewife Own Home						Gumboro Rd.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland Wicomico Pittsville			Pittsville									Gumboro Rd.						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
LAMBERT			Bratten			Northa Collins												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			297-32-7874			Elizabeth Knox			Gumboro Rd.			2 yrs						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			Malignant Melanoma with						4 mos						
1729						DUE TO, OR AS A CONSEQUENCE OF (b) Metastases												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (this hospital) attended the deceased from Aug 12, 1981, to Sept 22, 1981, that (we) last saw the deceased alive on Sept 22, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
Showes C Hill Jr			MD									9/22/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Thomas C. Hill Jr			Pine Bluff Road, Salisbury, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION			COUNTY	STATE					
Burial			9/24/1981			Friendship Cemetery			Pittsville									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Hill-Barker-Bounds, Salisbury, Md.						SEP 24 1981			Name: Jennifer									
BP _____																		
DHMH - 16 SOM 7/77 (VR A 15 (4))																		

13-26-1

13-26-1

222-33

13-26-1

222-33

13-26-1

13-26-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

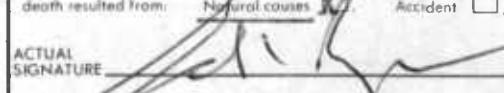
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit period. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8124918				
										REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Blanche			THOMAS			September 24, 1981			6:25 P M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			Dec. 9, 1892			88			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS. HOURS MIN.		
Gilberton, Pa.			U.S.A.						Wicomico			YRS.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK, IF MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
Salisbury			Deer's Head Center			Canning House			Canning					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Caroline			Preston						Rt. 1, Box 225, Preston, Md.		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME								
William H. Schultz						Idella G. Meyers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			burg, Md. 21632		
No			216-18-8145			Naomi Stafford, Rt. 1, Box 305B, Federalsburg								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
2506 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost														
(b) Due to, or as a consequence of Diabetes Mellitus														
(c) Due to, or as a consequence of Arteriosclerosis - generalised														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a cerebrovascular accidents														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE M. Shrestha			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Sep 29 1981					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept, 28, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Jr. Order Cemetery			23d. LOCATION CITY OR TOWN Preston, Caroline			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			ADDRESS Federalsburg,			25a. DATE REC'D. BY REGISTRAR SEP 29 1981			25b. REGISTRAR'S SIGNATURE Anne J. [Signature]					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24919	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR	
ISAAC			H.	TILGHMAN		<input checked="" type="checkbox"/>	<input type="checkbox"/>	9-3-81	19	6:	05P		
3. SEX		RACE	4. DATE OF BIRTH MONTH DAY YEAR	5. AGE (IN YEARS LAST BIRTHDAY) YRS.	6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
Male		AA	4 28 39	42		9-3-81	19	11	M				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA						Wicomico					
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital			Waterman			seafood					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS						
Md.		Somerset	Deal Island			YES <input checked="" type="checkbox"/>	Box 203						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Isaac				Tilghman	Dorothy			Parker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR/PEACE DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
yes Jan.'56-'59		214-34-5671			Barbara Tilghman, Deal Isl. Md.			Box 203					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY:		minutes											
IMMEDIATE CAUSE (a)		Myocardial Infarction											
2500 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		{ X} DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c)											
years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE  TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER													
DATE SIGNED 9-4-81													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial 9/6/81			23c. NAME OF CEMETERY OR CREMATORIAL John Wesley Cem.			23d. LOCATION City or Town Dear Island			County Som	State Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS Rt. 3, Box 354			25a. DATE REC'D. BY REGISTRAR SEP 14 1981			25b. REGISTRAR'S SIGNATURE 					
Webster Funeral Home, Princess Anne, Md.													

103. SMALL TREE. NO LEAVES ON. 45% V. 15% B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

6
page 3
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the funeral transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 1 2 4 9 2 0			
						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)	FIRST WILLIAM	MIDDLE York	LAST TINDALL	2a. DATE OF DEATH	MONTH 9---07-1981	DAY	YEAR	2b. HOUR 8:50 p.m.	
3. SEX <input checked="" type="checkbox"/> M	4. RACE <input checked="" type="checkbox"/> W	5. DATE OF BIRTH MONTH 3	DAY 7	YEAR 1903	6. AGE (IN YEARS LAST BIRTHDAY) 78 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO				
10. CITY OR TOWN OF DEATH SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor	12b. KIND OF BUSINESS OR INDUSTRY University			
13a. STATE New York	13b. COUNTY -----	13c. CITY OR TOWN New York	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 25 Claremont Avenue					
14. FATHER'S NAME FIRST Dr. William John Tindall	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Barbara Elizabeth Chudoba	MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO 119-24-6874	17. INFORMANT Mrs. Cecilia R. Tindall	ADDRESS 9 G. Layton - 64A Camden Ave. Ext. Salisbury, Md. 21801						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs.			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Multiple Sclerosis</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/1/81	21f. LOCATION STREET 19 76 to 9/7 19 87	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/7/81 to 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (hereinafter) did not see the body after death.									
22b. SIGNATURE EARL M. BEARDSLEY, M.D.						DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/8/81	
23a. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801									
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-12-1981	23c. NAME OF CEMETERY OR CREMATORIAL Green Mountain Cemetery Montpelier	23d. LOCATION CITY OR TOWN Montpelier	23e. COUNTY	STATE				
24. FUNERAL DIRECTOR HOLLOWAY FUN'L HOME P.A.	ADDRESS Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR SEP 14 1981	REGISTRAR'S SIGNATURE Anne Jeanne Miller				

W. M. Ladd

W. M. Ladd

W. M. Ladd 1891-1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 24921	
												REG. NO.	
1 - STATE REGISTRAR			I DECEASED NAME			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
			WALTER SYLVESTER Tingle						September 11, 1981				3:39 A.M.
3. SEX		Male	4. RACE		BLACK	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS
						MONTH	DAY	YEAR	62	MONTHS	DAYS	YRS	MONTHS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Philadelphia, PA	7b. CITIZEN OF WHAT COUNTRY?		U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH		Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
						retired			Laborer				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												MD.	
13a. STATE		MARYLAND	13b. COUNTY		Worcester	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	14. STREET ADDRESS			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. #3 Box 445				
14. FATHER'S NAME		Thomas	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				MIDDLE	LAST		
					TINGLE	SARAH					Pitts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		NO	16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
					Virginia Tingle			SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Brain tumor - glioma</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE (c)													
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
20a. MEDICAL CERTIFICATION		20b. DATE OF OPERATION		20c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20d. AUTOPSY?		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>81</u> , to <u>9/11</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Ben Hansen MD</u>		22c. DEGREE			22d. DATE SIGNED <u>9/11/81</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-15-81		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Jersey Rd.</u>			23d. LOCATION CITY OR TOWN <u>BERLIN</u> COUNTY <u>Worcester</u> STATE <u>Md.</u>		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <u>Frances Jean Hartman</u>				
24. FUNERAL DIRECTOR NAME <u>Jolley Memorial Chapel</u>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 18 1981</u>									
BP _____		DHMH-16 25M (VRA 15, 4) 1/79											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR PERSONAL USE. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24922

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR 1981 P.M.
Joseph F Torsella Sr.						<input type="checkbox"/>	9	4	1981	10:20 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.					
Male	White	11 25 51	29 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula Park Hospital			School Teacher					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Gwynn Oak	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS 3813 Arbutus Ave.		Balt., Md. 21207		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Frances		MIDDLE	LAST	Crocamo		
Frank A. Torsella Sr.										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Wife: Darlene R. Torsella		ADDRESS		Balt., Md. 21207		
No		215-56-5683						3813 Arbutus Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4029</i> Congestive Heart Failure sudden Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C.V. Disease years (c) Diabetes Mellitus years										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Earl L. Rogers</i>		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 409 Camdon Ave. Salisbury			DATE SIGNED 9-5-81					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Sept 9 1981	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery			23d. LOCATION CITY OR TOWN Woodlawn		23e. COUNTY Maryland	23f. STATE	
Burial										
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 8 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>			
Leonard J. Ruck, Inc.		Baltimore, Maryland								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

Item 6 g560 10/23/81 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 1 2 4 9 2 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			CRAWFORD	LEROY	Trader	September 30, 1981				5 15 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
MALE		NEGRO		MONTH	DAY	YEAR	78	73	MONTHS	DAYS	HOURS	MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.					
Maryland		U.S.A.				Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.					
Salisbury		Peninsula General Hospital		RETIRED		MINISTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1012 LAKE STREET					
14. FATHER'S NAME FIRST CHARLES		MIDDLE		LAST TRADER		15. MOTHER'S MAIDEN NAME ANNIE		MIDDLE SPENCE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO		16c. SOCIAL SECURITY NO. -----		12. INFORMANT MARGARET TRADER		ADDRESS SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c) PART I. DEATH WAS CAUSED BY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Candid pulmonay Arrest</u> 2028						5 min							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lymphoma infi</u> <u>lusions</u>						months							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>malignant Lymphoma</u>						UNKNOWN							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (this hospital) attended the deceased from <u>9/14</u> , 19 <u>81</u> , to <u>9/30</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>9/29</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>J. P. Meadows</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/30/81</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. P. Meadows</u>		22e. ADDRESS <u>Suite 31 Wesley Drive Salisbury MD</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 10/5/81		23c. NAME OF CEMETERY OR CREMATORIAL GREEN ACRES MEM. PK.		23d. LOCATION SALISBURY WICOMICO MARYLAND							
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL		ADDRESS Rt. #2, Jersey RD. SALIS., MARYLAND		25a. DATE REC'D. BY REGISTRAR OCT 8 1981		25b. REGISTRAR'S SIGNATURE <u>Frances Jean Kather</u>							

Santos County Hospital

Santos

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 24924								
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			September 5, 1981			12:45 P.M.					
RUTH M. TRADER																				
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female			Negro			11 04 33			47			YRS		MONTHS DAYS HOURS MIN						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD					
Maryland			USA									Wicomico								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital																	
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS								
Md.			Wicomico			Salisbury						921 D Booth St.								
14 FATHER'S NAME FIRST			MIDDLE			LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Cliford			Alton			Trader			Frances			Beatrice								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No			No			214-30-7696			Steve L. Trader			921-D Booth St.			months					
18 CAUSE OF DEATH: Enter only one cause per line for 1a, 1b, and 1c PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>																				
1574 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant Gastrinoma</u>			year		
															DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED									20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <u>7-10-81</u> , 19_____, to <u>9-5-81</u> , 19_____, that (I) (we) last saw the deceased alive on <u>9-5-81</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																				
22b. SIGNATURE <u>Earl L. Royer, M.D.</u>			DEGREE									ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9-8-81</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN			23e. COUNTY								
Burial			9-11-81			Green Acres Mem. Pk.			Salisbury			Wico.			Md.					
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR									25b. REGISTRAR'S SIGNATURE								
Russell Fooks, Seminole Blvd., Salisbury, Md.			SEP 14 1981									<u>James J. Neather</u>								
DHMH - 16 60M 1/75 (VR A 15 (4))																				

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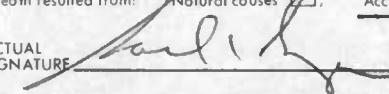
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24925				
1- STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
NANCY JEANNETTE WAGNER												<input checked="" type="checkbox"/>	9-7-81		1:30 P.M.	
SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	16 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	White	10/23/1964	16 yrs.			MONTHS	DAYS	HOURS	MIN.	Sept. 7 1981		"				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Salisbury, Md.			USA						WICOMICO							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital									Student				
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Ruxton Drive, Box 76					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		LAST					
Albert			Rollins			Wagner, Jr.			Connie		Roswell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			Ruxton Drive, Salisbury, Md. Mr. Albert R. Wagner, Jr. (father)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO, OR AS A CONSEQUENCE OF 8123 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger on motorcycle, struck car.										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
			highway			Rt. 50, 1 mi. east of Vienna, Wic., Md.										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
EXAMINER'S NAME (TYPE OR PRINT)												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				
Earl L. Royer, M.D.			ADDRESS 409 Camden Ave., Salisbury, Md.									DATE SIGNED 9/8/81				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/11/81			23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens			23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland			COUNTY STATE				
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR SEP 9 1981									25b. REGISTRAR'S SIGNATURE 				

Family Description

no spouse, no children, no dependents, 18-29 years old

new home, no job, no money, etc.

X

8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE
REGISTRAR

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

24926

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR 19 30A M				
RUSSELL Asbury WAINWRIGHT					<input checked="" type="checkbox"/>	9-26-81	8	30A	M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	AGE (IN YEARS) IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PROONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 11 M				
Male	White	6 16 11	70 yrs.		9-26-81								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					7d. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.								Wicomico			
18. CITY OR TOWN OF DEATH		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					21. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital			Poultryman					Broker Production			
22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
23. STATE Md.		24. COUNTY Worcester		25. CITY OR TOWN Berlin		26. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. STREET ADDRESS Rt. 3, Box 570					
28. FATHER'S NAME FIRST		MIDDLE		LAST		29. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST		
George		T.		Wainwright		Ado		E.			Mitchell		
30. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/>		(IF YES, GIVE WAR OR DATES)		31b. SOCIAL SECURITY NO. 213-18-4103		32. INFORMANT		ADDRESS Mrs Doris W. Wainwright Rt 3 Box 570 Berlin, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year	
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with Metastasis Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).													
34a. DATE OF OPERATION		34b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								35. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
36a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		36b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		36c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
37d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		37e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		37f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
38a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy		M.D.		MEDICAL EXAMINER		DATE SIGNED		9-28-81			
EXAMINER'S NAME (TYPE OR PRINT)		409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL FIL. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial 9/29/81		Taylorville Cemetery		Berlin		Wor.		Md.					
24. FUNERAL DIRECTOR/ BURIAL ADDRESS		25a. DATE REC'D. BY REGISTRAR Oct 2 1981		25b. REGISTRAR'S SIGNATURE H. Royer									
Burbage Funeral Home, Berlin, Md.													

1960 - 12 - 2
TUESDAY NOVEMBER 2
1960
Dense fog at 0700 hr of 12 miles visibility
continued.

1960 - 12 - 2
TUESDAY NOVEMBER 2
Visibility remained a constant 12 miles until
0900 hr of 12 miles visibility.

1960 - 12 - 2
TUESDAY NOVEMBER 2
Visibility remained a constant 12 miles until

1960 - 12 - 2
TUESDAY NOVEMBER 2
Visibility remained a constant 12 miles until

X X

X

1960 - 12 - 2

TUESDAY NOVEMBER 2
Visibility remained a constant 12 miles until

0900 hr of 12 miles visibility.

1960 - 12 - 2
TUESDAY NOVEMBER 2
Visibility remained a constant 12 miles until

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 24927 CERTIFICATE OF DEATH											
REG. NO. 5											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Mildred H. WARWICK</i>						<i>SEPTEMBER 9, 1981</i>				<i>6:00 A.M.</i>	
3. SEX			4. RACE	S. DATE OF BIRTH							
<i>FEMALE</i>			<i>WHITE</i>	<i>9/27/16</i>	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR	
BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	64			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
<i>MARYLAND</i>			<i>U.S.A.</i>				YRS.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK OR TRADE OF WORKING LIE)			12b. KIND OF BUSINESS OR INDUSTRY
<i>Salisbury</i>			<i>Peninsula General Hospital</i>					<i>NONE</i>			
13a. STATE <i>MD.</i>			13b. CITY OR TOWN <i>SOMERSET UPPER FAIRMOUNT</i>					13c. STREET ADDRESS			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					16. ADDRESS			
<i>ELMER MEREDITH</i>			<i>MYRTLE HOLLAND</i>					<i>MORRIS WARWICK UPPER FAIRMOUNT, MD.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO. <i>219-05-3025</i>					17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO								<i>MORRIS WARWICK</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Breast Cancer</i> i widespread metastasis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDIC ALEXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <i>8/23/81</i> 19 to <i>7/9</i> 19, that (I) <input type="checkbox"/> last saw the deceased alive on <i>9/8</i> 19 <i>81</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <i>Joseph N. Grasso</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>9/11/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph N. Grasso</i>		22e. ADDRESS <i>1300 S. Division St</i>									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE <i>9/12/81</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>BEAUCHAMP WOOD CEM.</i>		23d. LOCATION CITY STATE <i>PRINCESS ANNE, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 14 1981</i>			25b. REGISTRAR'S SIGNATURE <i>June Jan Martin</i>
24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.											

STATE INSURANCE COMMISSION

REGISTRATION NUMBER

REGISTRATION NUMBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

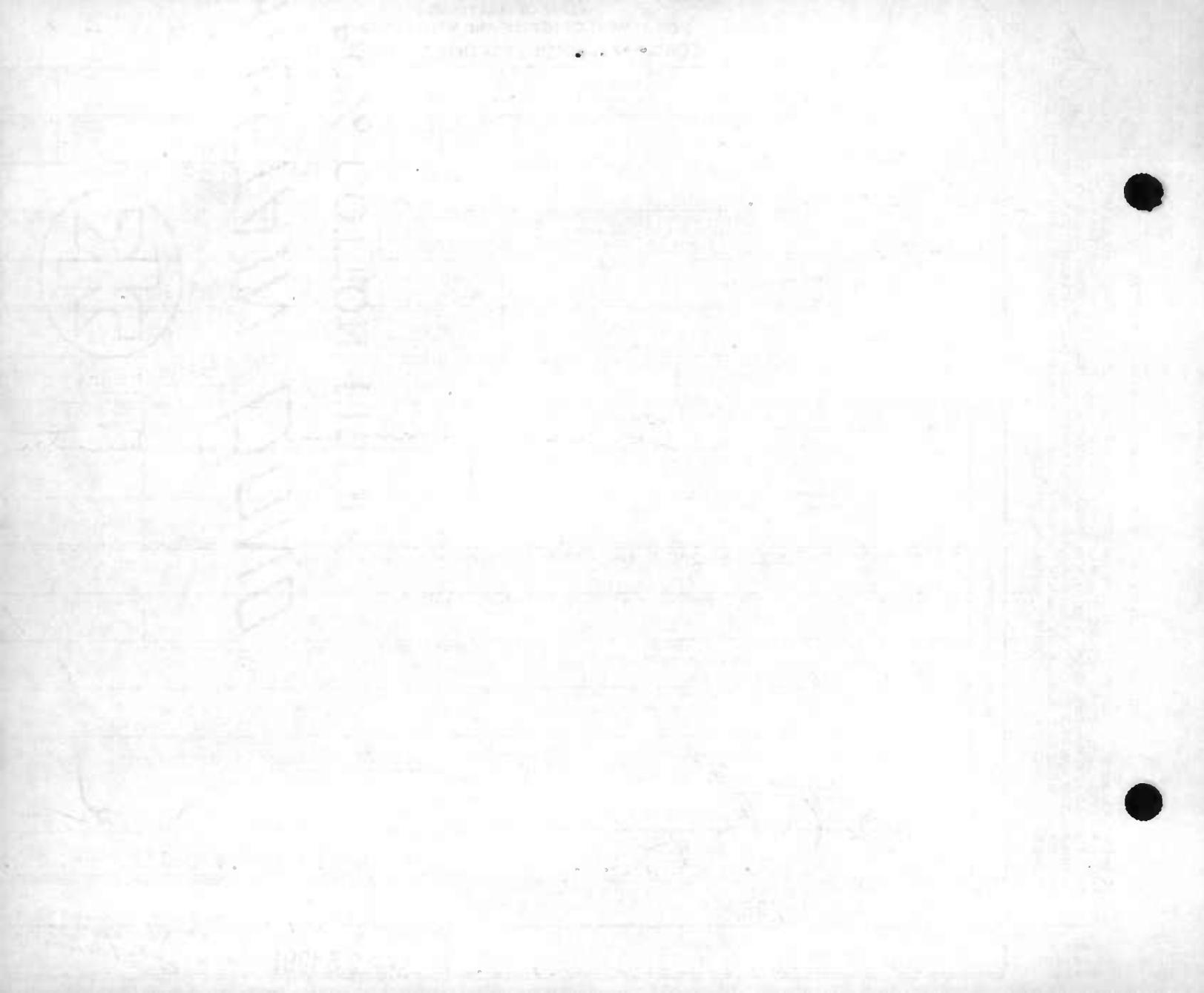
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or after a traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 9 2 8						
												REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
			Harold R.					White SR	September 29, 1981						M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			W			MONTH July 20 DAY 1904 YEAR			77			MONTHS	DAYS	HOURS	MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.						
Md			USA						Wicomico MD.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital						broker			seafood						
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS						
Md			Somerset			Chance			Main Road									
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME												
			William		White	Clementine			E Disharoon									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
no			--			218-12-1040			Mrs. Louise White, Chance, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Cerebral Thrombosis												
4029			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Hyperlipidosis & Atherosclerotic Cardiovascular Disease												
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-15-1981 to 9-22-1981, that (I) (we) lost saw the deceased alive on 9-29-1981 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
James L. Clifford						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9-29-81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
James L. Clifford			#12 Medical Center, Salisbury, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION									
burial			Oct. 2, 1981			Rock Creek Cem.			Chance			Som. County		Md. State				
24. FUNERAL DIRECTOR			ADDRESS			Rt. 3, box 354			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Leroy Webster			Princess Anne, Md.						OCT 7 1981			James Jan Warner						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

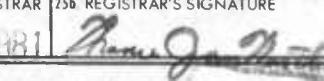
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24929						
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR	2b. HOUR 19 M	
		Daniel Palmer Willey																
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR 19 M	
Male		White		2/25/1936			45 yrs.							Sept. 21 1981				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH											
Princess Anne,		Md. USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			WICOMICO											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Salisbury		Peninsula General Hospital			Painter													
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Fruitland			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 112 S. Camden Ave.									
14. FATHER'S NAME FIRST Frederick		MIDDLE M.		LAST Willey			15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE LAST Bounds									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			same as 13 Mrs. Catherine Willey (mother)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Obstruction</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>								
4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) <i></i>			DUE TO, OR AS A CONSEQUENCE OF <i></i>													
(c) <i></i>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>Sol L. Royer</i>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.												ADDRESS 409 Camden Ave., Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/25/81		23c. NAME OF CEMETERY OR CREMATORIAL Allen Cemetery			23d. LOCATION CITY OR TOWN Allen		COUNTY Wicomico			STATE Maryland						
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 23 1981		25b. REGISTRAR'S SIGNATURE <i>Jones Janathen</i>											
BP _____																		
DHMH-17 (VR A15 ME (5)) 15M 2/80																		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24930
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
KENDRA RAE WILLIAMS						<input checked="" type="checkbox"/>	<input type="checkbox"/>	9-26-81	19	11:59	AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Female	White	9 16 71	10			<input type="checkbox"/>	<input checked="" type="checkbox"/>	9-26-81	19	"	M	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Peninsula General Hospital			Student			School			
13a. STATE De. County			13c. CITY OR TOWN Selbyville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O. Box 407			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Kenneth D. Williams			Dorothy Rae Moore									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
No			222-62-0702			Kenneth D. Williams, Selbyville						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
8252 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:55x 9-26-81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of motor bike, ran off road into ditch.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) farm			21f. LOCATION STREET McCabe farm, west of Selbyville, De.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED 9-28-81						
Earl L. Boyer, M.D.			409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN Bishopsville, Worc. MD			
Burial			9-29-81			Odd Fellows						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hastings Funeral Home, Selbyville, De.						Oct 1 1981						
BP												
DHMH-17 (VRA15 ME (5))												
15M2/80												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed together 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 9 3 1	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Lawrence -----					WINDSOR	SEPTEMBER 14, 1981					12 07 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White		Sept. 1, 1906			75			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Baltimore, Md.			USA					Wicomico					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital		employee			ice plant					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Wicomico		Delmar			YES <input type="checkbox"/> NO <input type="checkbox"/>			4 E. Chestnut Street		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST								
Unknown					Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
NO			214-32-2229A		Mrs. Nellie C. Windsor (wife) same as 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Normal</i>	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiopulmonary arrest</i> (c) <i>Other valve</i>												<i>Day</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>8/14/1901</i> to <i>8/15/1951</i> , that (I) (we) last saw the deceased alive on <i>8/14/1951</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, check here.)												22b. DATED SIGNED <i>8/14/81</i>	
22c. SIGNATURE <i>John G. Green MD</i>			22d. DEGREE <i>MD</i>			22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN G. GREEN MD</i>			22g. ADDRESS <i>QUINCY & LOCUST ST, SALISBURY, MD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/17/81		23c. NAME OF CEMETERY OR CREMATORIAL St. Stephens Cemetery			23d. LOCATION CITY OR TOWN Delmar, Sussex, Delaware		COUNTY	STATE		
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 16 1981			25b. REGISTRAR'S SIGNATURE <i>James J. Miller</i>				
BP _____													
DHMH - 16 50M 1/B (VRA 15, 4)													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at any time, or after traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	4	9	3	2
												REG. NO.						
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			Eugene Henry Wise						September 1, 1981			5:30 P.M.						
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
male			black			June 5, 1898			83			YRS.						
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital			laborer												
13a. STATE Md.			13b. COUNTY Wor.			13c. CITY OR TOWN Bishopsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. 2 Box 4						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Jim Wise			Henrietta Wise															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no			221-72-2916			Margaret Wilcox, Philadelphia, Pa.						2 years						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u> 4241 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic Insufficiency</u> DOUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Renal Failure.</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (this hospital) attended the deceased from <u>8-21-81</u> to <u>9-1-81</u> , that (I/we) last saw the deceased alive on <u>9-1-81</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I/we did not view the body after death.																		
22b. SIGNATURE <u>Rose M. Martin</u>			DEGREE MS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9-1-81</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/5/81			23c. NAME OF CEMETERY OR CREMATORIAL Curtis Cemetery			23d. LOCATION CITY OR TOWN Bishopsville, Wor. L., Md.			COUNTY STATE						
24. FUNERAL DIRECTOR NAME <u>Frederick T. Watson</u>			24b. DATE REC'D. BY REGISTRAR SEP 8 1981			24c. REGISTRAR'S SIGNATURE <u>Frances Jan Martin</u>												
BP																		
DHMH - 16 50M 1/B (VRA 15, 4)																		

de la morte

seulement gérante négative

modèle

de la morte

subjectivisant

l'opposition

et l'opposition à l'opposition

| 181 P. R. L. A. et son fils

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
IRMA				B.	YOUNG		SEPTEMBER 1 1981				12 P.M.		
SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
FEMALE		WHITE		JULY 26, 1918		63 YRS							
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
MARYLAND		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Salisbury		Peninsula General Hospital										TEACHER	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS			
MARYLAND		WORCESTER		BISHOPVILLE						P.O. Box 386			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				ADDRESS				
EDWARD		I	L	BRITTINGHAM	ETHA				MORRIS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		219-03-0076		RUTH HAZZARD, OCEAN CITY, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant lymphoma stage IV B</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>81</u> , to <u>9/1</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/1</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>J. S. Jr.</u>		22c. DEGREE <u>Hb</u>		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-4-81		23c. NAME OF CEMETERY OR CREMATORIAL ODD FELLOWS				23d. LOCATION CITY OR TOWN BISHOPVILLE, WORC. MD.					
24. FUNERAL DIRECTOR NAME <u>Charles W. Hastings</u>		ADDRESS <u>SELBYVILLE, DE</u>		25a. DATE REC'D. BY REGISTRAR SEP 8 1981				25b. REGISTRAR'S SIGNATURE <u>Charles Jean Harten</u>					

outlook

foreign trade situation - continues

the US to buy more imports

and demand for exports will increase

and demand for imports will decrease

and demand for exports will increase

and demand for imports will decrease

and demand for exports will increase

and demand for imports will decrease

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